Patient#_____

Palm Family Eyecare
201 Dakota St. Sutherlin OR 97479

P. 541-459-4333
F. 541-459-7512

Medical History

Name:_____ Date _____/_____/_____

Mailing Address_____
Box/Street City State Zip

Date of Birth_____/_____/_____ SS#_____-_____-_____ Phone Number _____

Cell Number _____ Text Msg YES / NO Email Address_____

Primary Care Physician_____ Dr. Phone_____

Occupation_____ Spouse Name_____Last Eye Exam_____

Primary Insurance_____ Secondary Insurance_____

Preferred Language_____ Race_____ Hispanic/Latina or Non-Hispanic (Circle one)

Eye History

History of Eye Surgery_____History of Eye Infection_____

Medical History

List any medications you take: _____

Are you allergic to any medications?_____

Do you currently have any of the following: (Check the relevant option when it applies)

	No	Yes		No	Yes
Diabetes			Asthma/Emphysema/COPD		
High Blood Pressure			Rheumatoid Arthritis		
Heart Problem			Muscle/Joint pain/Arthritis		
High Cholesterol			Gastrointestinal Disorder		
Anemia/Blood Disorder			Kidney/Bladder/Liver Disorder		
Thyroid/Endocrine Disorder			Immunologic Disorder		
Seizures			Are you Pregnant		
Skin Disorders			Allergies/ Hay Fever		
Headaches/Migraines			Psychiatric Disorders		
Cancer			Smoker/Tobacco Use		

Eye Problems

Glaucoma			Eye pain		
Macular Degeneration			Itching/Burning/Dryness		
Flashes/Floaters			Excess Tearing/Redness		

***If you answered yes to any of the above or have a condition not listed, please explain:**

_____

Family History (Is there a history of the following in your **family**)

	No	Yes	Relationship		No	Yes	Relationship
Blindness			_____	Cancer			_____
Crossed Eyes			_____	Diabetes			_____
Glaucoma			_____	Heart Disease			_____
Macular Degeneration			_____	Thyroid Disease			_____
Retinal Detachments			_____	High Blood Pressure			_____

Patient or Guardian Signature _____ **Date**_____

Patient Review Date / Initial Dr. Review Date / Initial

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Patient Name: _____ Responsible Party's Phone _____

Mailing Address _____
Box/street City State Zip

Employer _____ Work Phone _____

Social Security Number: _____ Date of Birth _____

PRIMARY MEDICAL for the patient
Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law

Policy Holder's Name _____
First Middle Int. Last

Insurance Name _____ Group Name/Employer _____

Group # _____ *Policy ID#* _____ *Effective Date* _____

Policy Holder's Date of Birth _____ Policy Holder's SS# _____

COMPLETE NAME OF FAMILY MEMBERS ON PLAN

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Palm Family Eyecare to render needed treatment to the above named patient.
2. I authorize Palm Family Eyecare to release information regarding my treatment to my insurance company for billing purposes.
3. I authorize payment of benefits to Palm Family Eyecare for services rendered.
4. I understand that I am responsible for all charges incurred through Palm Family Eyecare.

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees, court costs and collection fees of $75.00.

Signature _____ Date _____

Signature _____ Date _____

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ACKNOWLEDGMENT AND CONSENT

I understand that Palm Family Eyecare, referred to below as ("This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

1) make decisions about and plan for my care and treatment;
2) refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
3) determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
4) perform various office, administrative and business functions that support my physician's efforts

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I shall receive a copy of the Notice of Privacy Practices upon request.

By: _____ Date: _____
Patient

By: _____ Date: _____
Patient Representative

Description of Representative's Authority: