PeposeVision INSTITUTE

NEW PATIENT INFORMATION FORM

Whom may we thank for referring you? ☐ Family/Friend ☐ Doctor: _____ ☐ TV/Print

LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY #**: _____
ADDRESS: _____ **HOME PHONE #:** _____
_____ **CELLPHONE #:** _____
_____ **EMAIL**: _____

RACE*: ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ African American
☐ Asian ☐ American Indian ☐ Other: _____

ETHNICITY*: ☐ Hispanic/Latino ☐ Other

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____
PHONE #: _____

******Please fill out the insurance information below **ONLY** if you are **NOT** the primary card holder******

PRIMARY INSURANCE: _____
SECONDARY INSURANCE: _____

POLICY HOLDER'S INFORMATION
LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY#**: _____
ADDRESS: _____ **PHONE #:** _____
_____ **SECONDARY #:** _____
_____ **EMAIL**: _____
EMPLOYER: _____ **OCCUPATION**:_____

Authorization to Release Medical Information:

I hereby authorize the physician, to release any information from Patient Medical Records required in the course of my examination and treatment to any insurance company against which claims are filed for me or my dependents.

I am aware of my rights to privacy of personal health information under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Occasionally you may be contacted by our affiliated nonprofit Foundation (Lifelong Vision Foundation) to inform you of (i) new clinical studies that may be appropriate for your specific vision condition; or (ii) new community-based outreach programs that you may wish to support as a volunteer or donor. Should you wish to opt out of these communications please initial here. _____

I understand payment for all office services is expected at the time of my visit, unless other arrangements have been made prior to my visit. I hereby authorize payments to be made directly to PVI for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay ALL collection fees and court costs.

_____ _____ _____
Patient or Guardian Signature Relationship Date

NEW PATIENT QUESTIONNAIRE

LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____

PRIMARY CARE DOCTOR: _____

ADDRESS: _____ **PHONE #:** _____

_____ **SECONDARY #:** _____

_____ **EMAIL**: _____

PHARMACY NAME*: _____ **PHARMACY #:** _____

1. **Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
2. **Have you ever been diagnosed with any eye disease (glaucoma, cataract, "lazy" eye, retinal detachment)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
3. **Have you ever had surgery?**
   ☐**Yes** ☐**No** If yes, please explain: _____
4. **Do you take any medications?**
   ☐**Yes** ☐**No** If yes, please list: _____
5. **Are you allergic to any of the following drugs (check the box for all that apply)?**
   ☐**Sulfa** ☐**Cipro** ☐**Levequinn** ☐ **Aspirin**
   ☐**Other:** _____
6. **Do you currently have any of the following problems?** ☐ **Yes** ☐**No**

   A.) Chronic Fever, unexpected weight loss/gain, fatigue, Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat) If yes, explain: _____

   B.) Heart Problems (e.g. chest pain, irregular heart beat)? ☐ **Yes** ☐**No** If yes, explain: _____

   C.) Respiratory Problems (e.g. shortness of breath, wheezing)? ☐ **Yes** ☐**No** If yes, explain: _____

   D.) Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting)? ☐ **Yes** ☐**No** If yes, explain: _____

   E.) Urinary problems (e.g. blood in urine, pain)? ☐ **Yes** ☐**No** If yes, explain: _____

   F.) Skin problems (e.g. rashes, excessive dryness)? ☐ **Yes** ☐**No** If yes, explain: _____

   G.) Neurological problems (e.g. numbness, weakness, Headache, paralysis)? ☐ **Yes** ☐**No** If yes, explain: _____

   H.) Psychiatric problems (e.g. depression, anxiety)? ☐ **Yes** ☐**No** If yes, explain: _____
7. **Do you smoke?*** ☐**Current every day** ☐ **Current some days** ☐ **Former: from**_____ **to** _____ ☐ **Never** ☐ **Unknown**
8. **Do you drink alcohol?** ☐ **Yes** ☐**No** If yes, how much? _____
9. **Weight:** _____**lbs** **Height:** _____**ft.** _____**in.**

Reviewed by M.D.: _____**Date:** _____

COMMENTS: _____

PeposeVision
INSTITUTE

PEPOSE VISION INSTITUTE, P.C.

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Pepose Vision Institute, P.C. to disclose my personal medical information to the following individual(s).

☐ Pepose Vision Institute, P.C. may disclose my medical information only in my presence.
☐ Pepose Vision Institute, P.C. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.
☐ I understand that consent may be revoked by me at anytime by written notice of Pepose Vision Institute, P.C.

Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____

☐ Person(s) listed above age 18 or older may pick up prescription when I am not present.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

☐ I have received the Pepose Vision Institute Notice of Privacy Practices.

_____ _____
Patient or Guardian Signature Date

PEPOSE VISION INSTITUTE FINANCIAL POLICIES

We are glad you have chosen us for your vision care. Full payment for all services provided is expected on the day of your visit unless you have health insurance coverage with a plan with which we have a written agreement **and** the service is a covered service under your plan. Your insurance provider **requires us to collect all applicable deductibles and copayments at the time that any medical service is provided**. Such payments, as well as payments for noncovered services, may be paid by cash, check (under $200) or credit card (Visa, MasterCard, Discover). There is a fee of $25 for any checks returned by the bank.

We must have a copy of the front and back of your insurance card(s) along with your driver's license or other photo ID at your initial visit. You may be asked to provide your insurance card at subsequent visits. We will require the name, date of birth, address, telephone number and employer of the family member through whom you are insured. You are responsible for notifying us (1) of any change in address, telephone number, employer or insurance coverage; and (2) whether your insurance coverage requires a referral to our office or pre-certification for any services rendered. Should your insurance deny payment of your medical claim for either reason, you are financially responsible for any outstanding charges for services rendered.

PATIENT INITIALS: _____

REFRACTION POLICY

A refraction is a measurement of lens power necessary to prescribe glasses or other corrective lenses. Most insurance plans, including Medicare, DO NOT cover routine refractions (when no medical eye problem is known or suspected). Insurance companies permit us to charge separately for this refraction since it is not included in your covered eye exam. Upon payment of this fee, you may request a copy of your refraction in order to purchase prescription glasses.

THE FEE FOR THIS SERVICE IS $69

PATIENT INITIALS: _____

AUTHORIZATION OF PAYMENT: I hereby authorize payments to be made directly to PVI for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay all collection fees and court costs.

_____ _____

Name of Patient (Print) Signature / Date

_____ _____

Name of Responsible Party (Print)
[If not Patient]

Signature/ Date