PATIENT REGISTRATION

Name:	Sex:	Age:	Birth date:
Address:	Apt. #	Last Four Digits Of Social Security #: XXX-XX-____	
City: State:	Zip:	Home Phone: ( )	Alternate Phone: ( )

What vision concerns brought you here today?

_____

_____

Date of last eye exam: **Dilated? Y N**

Occupation: _____

Hobbies: _____

Name of Primary Care Physician:

_____

Your Eye History

Currently wear glasses?	Y	N
Currently wear contacts?	Y	N
Blurry distance vision?	Y	N
Blurry near vision?	Y	N
Ambiyopia (Lazy Eye)	Y	N
Headaches	Y	N
Mucous Discharge	Y	N
Floaters / Spots	Y	N
Double Vision	Y	N
Glare	Y	N
Excess Tearing / Watering?	Y	N
Eye Injury	Y	N
Eye Surgery	Y	N
Glaucoma	Y	N
Cataracts	Y	N

Other: _____

Your Medical Health History

Endocrine (Thyroid, etc.)	Y	N
Ear/Nose/Throat	Y	N
Muscles/Bones/Joints	Y	N
Immune System	Y	N
Gastrointestinal	Y	N
Respiratory (Asthma)	Y	N
Mental	Y	N
Cardiovascular	Y	N
Skin Disorder	Y	N
Diabetes	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Cancer	Y	N

Other: _____

Your Family History

Diabetes	Y	N
High Blood Pressure	Y	N
Cancer	Y	N
Heart Disease	Y	N
Blindness	Y	N
Glaucoma	Y	N
Cataracts	Y	N
Macular Degeneration	Y	N
Crossed Eyes	Y	N
Lazy Eye	Y	N
Color Blind	Y	N

Other: _____

Social History:

Do you use cigarettes?	Y	N
Do you use alcohol?	Y	N

List your current medications: _____

_____

Allergies: **N** **Y (list)** _____

Consent to Use or Disclose Health Information for Treatment, Payment and Healthcare Operations / (HIPAA) Agreement

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. We have a comprehensive "Notice of Privacy Practices" that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our "Notice", the use and disclosure of your health information for treatment purposes may not only include care and services provided here, but also disclosures as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use of your health information for purposes of payment includes our submission of your health information to a billing agent for processing claims and obtaining payment; determination of your benefits; or submission of your claim to third party auditors. Our "Notice" will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify that you agree that we can use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed healthcare operations in reliance upon our ability to use your information in accordance with this consent. We can decline to serve you if you elect not to sign this form. If you require more detailed information about our Privacy Practices please refer to our comprehensive "Notice" located in our office.

I consent to this Clinic and release aspects of my health information to the following people. (List names and relationship)

_____ _____ _____

MY SIGNATURE AT THE BOTTOM OF THIS FORM INDICATES THAT I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Please Read Financial Policy Below:

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Troutdale Vision Clinic. I understand that my primary insurance will be billed. As a courtesy, Troutdale Vision Clinic will bill my secondary insurance. I understand that all benefits quoted to me are not a guarantee of payment and all overages and co-payments are due today.

Signature: _____ E-mail address: _____ Date: _____