PATIENT REGISTRATION

PLEASE PRINT ALL INFORMATION

NAME:_____ Nickname: _____ DOB:_____ SSN:_____

STREET ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PRIMARY PHONE#_____ SECONDARY PHONE#_____ EMAIL:_____

SEX: ❑MALE ❑FEMALE LANGUAGE: ❑ENGLISH ❑SPANISH ❑OTHER: _____ ETHNICITY: ❑HISPANIC ❑NOT HISPANIC

MARITAL STATUS: ❑SINGLE ❑MARRIED ❑OTHER RACE: ❑BLACK/AFRICAN AMERICAN ❑WHITE ❑OTHER:

EMPLOYMENT STATUS: ❑STUDENT ❑FULLTIME ❑PARTTIME ❑RETIRED ❑NOT EMPLOYED ❑ACTIVE MILITARY ❑DISABLED

EMPLOYER/SCHOOL:_____ POSITION:_____ ADDRESS:_____

REFERRED BY:_____

RESPONSIBLE PARTY (IF UNDER 18)_

NAME:_____ DOB:_____ SSN:_____

EMERGENCY CONTACT/RELATIONSHIP:_____ TELEPHONE #:_____

RELEASE OF INFORMATION

HIPPA RELEASE FORM- BY SIGNING BELOW I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

[ ] SPOUSE: _____

[ ] CHILD AND/OR CHILDREN: _____

[ ] OTHER: _____

[ ] INFORMATION IS NOT TO BE RELEASED TO ANYONE.

THIS *RELEASE OF INFORMATION* WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL MY: [ ] HOME [ ]WORK [ ]CELLPHONE

NUMBER:_____

IF UNABLE TO REACH ME YOU MAY LEAVE A MESSAGE

[ ] DETAILED- YES OR NO

[ ] GENERALIZED INFORMATION AND/OR TO RETURN YOUR CALL

SIGNED:_____ DATE:_____

WITNESS: _____ DATE:_____

Acknowledgment of Notice of Privacy Practices

The law requires that Corinth Eye Clinic, Inc make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

(PLEASE MARK ONLY ONE)

_____ I have read or had explained to me prior to any services offered Corinth Eye Clinic, Inc's Notice of Privacy Practice and agree to continue my care with Corinth Eye Clinic, Inc under said terms.

_____ I was given the opportunity to read Corinth Eye Clinic, Inc's Notice of Privacy Practices and declined but wish to continue my care with Corinth Eye Clinic, Inc under the terms of Corinth Eye Clinic, Inc's privacy polocies.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name of Patient's Representative (if applicable) **Relationship to Patient**

Fees & Payments

We make every effort to keep down the cost of your medical care. You can help by paying in full upon the completion of each visit. If you have any vision and/or medical insurance we will be glad to fill out the proper forms or file the claim for you, but please complete the identifying information within this paperwork.

If you are using insurance coverage for today's visit--this is a contract between you and your insurance company, not Weeden Eye Clinic, Inc., or Dr. Michael Weeden. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures or items and others pay a percentage of the charge.

I certify that the insurance information that is on this form or provided to this office is accurate. I understand I am financially liable for any deductible amount, co-insurance & non-covered services or any other balance not paid by my insurance company(s). I understand that you may bill me if my insurance company takes longer than 90 days to pay your office. If my insurance company denies payment, I agree to be personally responsible for payment. If I have no insurance, I understand that I am responsible for the entire balance of services and products provided. I will be responsible for all collection costs, attorney's fees, and court costs should my account be turned over to collection.

_____ DATE _____

SIGNATURE OF PATIENT (Parent or Guardian if minor)

Insurance Authorization

This signature on file is my authorization for the release of information necessary to process my insurance claim. I hereby authorize payment to this doctor or office named of the benefits otherwise payable to me. This signature may be used for all insurance claims unless revoked in writing.

_____ DATE _____

SIGNATURE OF PATIENT (Parent/Guardian if minor)

Dry Eye Questionnaire

Patient name _____

1. Questions about EYE DISCOMFORT:
   a. During a typical day in the past month, how often did your eyes feel discomfort?
      ❑ 0 Never
      ❑1 Rarely
      ❑3 Sometimes
      ❑4 Frequently
   b. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

Never have it		Not at all Intense			Very Intense
0❑	1❑	2❑	3❑	4❑	5❑

2. Questions about EYE DRYNESS:
   a. During a typical in the past month, how often did your eyes feel dry?
      0❑ Never
      1❑ Rarely
      2❑ Sometimes
      3❑ Frequently
      4❑ Consistently
   b. When your eyes feel dry, how intense was this feeling of dryness at the end of the day, within two hours of going to bed?

Never have it		Not at all intense			Very Intense
0❑	1❑	2❑	3❑	4❑	5❑

3. Questions about WATERY EYES:
   a. During a typical day in the past month, how often did your eyes look or feel excessively watery?

0❑ Never

1❑ Rarely

2❑ Sometimes

3❑ Frequently

4❑ Consistently

Score: 1a + 1b + 2a + 2b + 3 = Total

_____ + ____ + ____ + _____+ ____= _____

Medical History Questionnaire

Name: _____ DOB: ___/___/___ Date ___/___/___

Medical History:

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain _____

_____

PRIMARY CARE PHYSICIAN(Name&Location)_____

PHARMACY(Name&Location)_____

List any **Medications** you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

_____

Circle any of the following that you have had: Hysterectomy, Gallbladder, Vertebra, Vasectomy, Appendectomy, Tonsillectomy, T & A (tonsils and adenoids), Cataract Surgery, Lasik, Sleep Apnea, Stents, List any others:_____

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Dropping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections, or Eye Injury.

Are you pregnant and or nursing? ❑ No ❑ Yes

Do you wear glasses? ❑ No ❑ Yes

Do you wear contact lenses? ❑ No ❑ Yes

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes

Family History:

Please note any family history (Parents, Siblings, and Children living or deceased for the following medical conditions), all others NOT marked will be considered NEGATIVE:

DISEASE / CONDITION	Yes	RELATIONSHIP TO YOU					
Blindness	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Cataract	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Crossed / Lazy Eye	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Glaucoma	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Macula Degeneration	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Retinal Detachment/Disease	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Arthritis	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Cancer	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Diabetes	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Heart Disease	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
High Blood Pressure	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Kidney Disease	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Lupus	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Hyperthyroid Disease	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Hypothyroid Disease	❑	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter

Other:_____

Social History:

Do you use tobacco products? ❑ No ❑ Yes _____packs per day

Do you drink alcohol? ❑ No ❑ Yes

Do you work at a computer/VDT? ❑ No ❑ Yes

Do you use addictive agents? ❑ No ❑ Yes

Have you been exposed to or infected with: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis ❑ None

Your Medical History: Review Of Systems: Please indicate all of the following POSITIVE medical conditions pertain to you. All unmarked will be considered NEGATIVE.

Constitutional:	**Yes**
Developmental Disabilities	❑
Weight Loss/Gain	❑
Fever	❑
Fatigue Syndrome	❑
Trauma	❑
Cancer	❑
Other	❑

Ears, Nose, Mouth, Throat:	**Yes**
Hearing Loss	❑
Sinusitis	❑
Dry Mouth	❑
Laryngitis	❑
Chronic Cough	❑
Other	❑

Neurologic:	**Yes**
Multiple Sclerosis	❑
Epilepsy	❑
Cerebral Palsy	❑
Tumor	❑
Stroke/CVA	❑
Migraines	❑
Headaches	❑
Autism Spectrum Disorder	❑
Other	❑

Psychiatric:	**Yes**
Depression	❑
Attention Deficit	❑
Anxiety Disorder	❑
Bipolar Disorder	❑
Schizophrenia	❑
Other	❑

Cardiovascular:	**Yes**
High Blood Pressure	❑
Stroke/CVA	❑
Heart Disease	❑
Vascular Disease	❑
Congestive Heart Failure	❑
Other	❑

Respiratory:	**Yes**
Cigarette Smoker	❑
Asthma	❑
Chronic Bronchitis	❑
Emphysema	❑
Chronic Obstruction(COPD)	❑
Sleep Apnea	❑
Other	❑

Gastrointestinal:	**Yes**
Crohn's	❑
Colitis	❑
Ulcer	❑
Acid Reflux	❑
Celiac Disease	❑
Other	❑

Genitourinary:	**Yes**
Kidney Disease	❑
Prostate Disease/Cancer	❑
STD- herpetic/chlamydia	❑
Benign Prostate Hypertrophy	❑
Pregnant	❑
Nursing	❑
Herpes	❑
Chlamydia	❑
Other	❑

Muskuloskeletal:	**Yes**
Arthritis	❑
Osteoarthritis	❑
Fibromyalgia	❑
Muscular Dystrophy	❑
Ankylosing Spondylitis	❑
Osteoporosis	❑
Gout	❑
Other	❑

Integumentary:	**Yes**
Eczema	❑
Rosacea	❑
Psoriasis	❑
Herpes Simplex/Cold Sores	❑
Herpes Zoster/Shingles	❑
Other	❑

Endocrine:	**Yes**
Diabetes Type 1	❑
Diabetes Type 2	❑
Thyroid Dysfunction	❑
Hormonal Dysfunction	❑
Other	❑

Lymphatic/Hematologic:	**Yes**
Anemia	❑
Large-volume Blood Loss	❑
Leukemia	❑
Blood Thinner	❑
Ulcer	❑
Hypercholesteremia	❑
Other	❑

Allergic/Immunologic:	**Yes**
Drug Allergies	❑
Environmental Allergies	❑
Rheumatoid Arthritis	❑
Lupus	❑
Sjogren's Syndrome	❑
Other	❑

Eyes:	**Yes**
Cataract	❑
Macular Degeneration/ARMD	❑
Glaucoma	❑
Dry Eye	❑
Eye Infection	❑
Eye Inflammation	❑
Eye Allergy	❑
Floaters/Flashes of Light	❑
Iritis/Uveitis	❑
Retina Defects/Degenerations	❑
Redness	❑
Burning	❑
Itching	❑
Tearing	❑
Discharge	❑
Stringy Mucus in or around eye	❑
Foreign Body Sensation	❑
Contact Lens Discomfort	❑
Scratchy/Sandy/Gritty Sensation	❑
LASIK	❑
Cataract Surgery	❑
Blurred Vision	❑
Eyestrain	❑
Eye Pain	❑
Severe Light Sensitivity	❑
Headache	❑
Poor Night Vision	❑
Bothersome Night Glare	❑
Double Vision	❑
Total Loss of Vision	❑
Other	❑

(OFFICE USE ONLY)

P, F, S Hx Prob Pertient (1area) _____
Complete (2-3 areas) _____
ROS Prob Pertient (1 sys) _____
Ext. (2-9) _____
Complete (>10) _____

☐ Primary ROS taken today
☐ Reviewed ___/__/___ ROS & PFSH today
Changes Noted:

Initials: _____ Date: _____

Case History:

❑Prob-focused ❑Exp. Prob-foc

❑Detailed ❑Comrehensive

SIGNATURE OF PATIENT

X_____ Date _____