



WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

First Name _____ Middle Name _____

Address _____

City _____

State _____ Zip _____

Phone Numbers: Home () _____

Work () _____ Cell () _____

Best Phone Number to call Home Cell Work

E-mail _____

Sex M F *Age _____ Birthdate _____

Married Single Minor

Social Security Number _____

Occupation _____

Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Phone () _____ Relationship _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient Self Spouse Parent Other

Birthdate _____ SS# _____

Insurance Co. _____

Subscriber # _____

Employer _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Northgate Vision Center, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

CONSENT TO TREAT A MINOR

I give Northgate Vision Center permission to treat _____

Signature

Print Name

Relationship to Minor

Health Insurance Portability and Accountability Act (HIPAA) PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Policy: We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our notice of privacy practices, please request one today or at any time in the future.

I understand that Northgate Vision Center, P.C. has a notice of privacy practice which is available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I:

____ accept the notice of privacy practices.

____ decline receiving a copy of the notice of privacy practices, even though I may receive a copy at any time upon request.

Signed _____ Date _____

Patient or Guardian

EYE HEALTH HISTORY

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? Yes No

All the time Occasionally
 Reading Drive TV

Do you wear contacts? Yes No

type _____ Hours/Day _____

Describe any problems you have with your contacts _____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

- | | | | |
|----------------------------|--|--------------------------|--|
| Bloodshot eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Itching Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light Sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge from Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Halos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Flashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Twitching Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

- | | Yourself | Family Members | | Yourself | Family Members |
|------------------------|--|--|--|--|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lazy Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor Color Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Turned Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis (Type _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | | |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? _____ | Number of children _____ | |
| | | | Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasional | |

MEDICATIONS

List any medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

List your allergies to medications or other substances:

HOBBIES

To better advise you on your vision needs please take the time to check off hobbies you engage in regularly.

- | | | | | |
|-------------------------------------|---|-------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Art | <input type="checkbox"/> Computer Games | <input type="checkbox"/> Gardening | <input type="checkbox"/> Puzzles | <input type="checkbox"/> Woodwork |
| <input type="checkbox"/> Cards | <input type="checkbox"/> Cooking | <input type="checkbox"/> Needlework | <input type="checkbox"/> Reading | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Collecting | <input type="checkbox"/> Crafts | <input type="checkbox"/> Pottery | <input type="checkbox"/> Sewing | <input type="checkbox"/> Other _____ |

COMPUTER

Do you work on a computer? YES NO If so, how many hours a day? _____ Distance of Monitor from eyes _____ inches _____ feet

Do you experience headaches or eye strain during or after use? YES NO

Do you experience blurred vision after computer use? YES NO