Eye Contact Patient Registration and History

In order or comply with US Federal Government "meaningful use" regulations for Electronic Health Record (EHR) software, Eye Contact is implementing the required steps necessary with this questionnaire. The questions may seem somewhat intrusive; however, we are complying only with the steps that are required of us. We appreciate your patience!

Name: _____
(last) *(first)*

Primary Language: _____ Height: _____ Weight: _____

Ethnicity *(circle)*: Caucasian African American Asian Native Hawaiian or Other Pacific Islander Hispanic or Latino American Indian or Alaska Native Decline to Answer

FAMILY HEALTH HISTORY

Are you adopted? Yes No

	Self		Family		Relative
	No	Yes	No	Yes	
Blindness					
Cancer					
Cataracts					
Diabetes					
Glaucoma					
Hypertension					
Lazy Eye/Amblyopia					
Age-Related Macular Degeneration (AMD)					

Please list all current medications and vitamins:

_____

_____

_____

_____

SOCIAL HISTORY

This information is kept strictly confidential.

Do you use cigarettes/tobacco?	**No**	**Yes**
Current every day smoker		
Current some day smoker		
Former smoker		
Heavy tobacco smoker		
Light tobacco smoker		
Never smoker		

Do you use alcohol?	**No**	**Yes**
Non-drinker		
Social drinker		
Weekend drinker		
Trivial drinker (<1 drink/day)		
Light drinker (1-2 drinks/day)		
Moderate drinker (3-6 drinks/day)		
Heavy drinker (7-9 drinks/day)		
Very heavy drinker (>9 drinks/day)		

Insurance and Payment Authorization

Today's Professional Fees will be paid for by:
Cash/Check Credit Card Medicare Vision Insurance

Insurance Company:
ID# :

I request that payment of authorized insurance benefits be made on my behalf to Eye Contact. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by Eye Contact. I understand and agree that regardless of my insurance benefits, I (or the account responsible party) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur a 1.5% late fee on all balances of 60 days or more unless financial arrangements are made, and accounts over 90 days may be forwarded to a collection agency.

_____

Signature Date