Illinois Eye Associates™

New Patient Registration

Please verify the following information, make necessary changes and supply any missing information.

Today's Date

Patient Information

Patient Name (First, Middle, Last)	Suffix (Jr., Sr)	Salutation	Nickname	Date of Birth	Age	Sex

Street Address	City, State	Zip Code

Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)

Race: Please Circle One	Primary Language	Ethnicity: Please Circle One
White/Caucasian Black or African American Native Hawaiian/Pacific Islander American Indian/Alaska Native Asian Other_____ Decline to answer		Not Hispanic or Latino Hispanic or Latino Decline

HIPAA Contact (Approved to discuss/release medical information)

Name	Phone Number

Relationship to the patient Is this person also your Emergency Contact: Yes_____ No _____

If No: Name: Phone:

Primary Insurance

Insured's Name	Date of Birth
ID Number	Group Number
Insurance Company Name	Insurance Co. Phone
Insurance Company Address	

Vision Insurance

Insured's Name	Date of Birth
ID Number	Group Number
Insurance Company Name	Insurance Co. Phone
Insurance Company Address	

Primary Care Physician:_____ Phone:_____

Town:_____ Fax:_____

INSURANCE AUTHORIZATION:

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Illinois Eye Associates, Ltd. all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or personally. I authorize the use of my signature on all insurance submissions. If my bill is not paid by insurance, I understand I am responsible for any charges. A $25 fee will be applied to all checks with insufficient funds.

Illinois Eye Associates may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I further consent to the disclosure of my health information in order for another provider or health care entity to conduct health care operations, including quality assessment and reviewing the competence of health care professionals. I consent to allowing Illinois Eye Associates to obtain my previous records from other health care providers if deemed necessary for my care.

I further acknowledge that Illinois Eye Associates, Ltd. has made available to me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature: _____ **Date:** _____ **Relationship to Patient:**_____

NEW PATIENT EXAMINATION/MEDICAL HISTORY

Ocular History

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Age of Current Glasses: _____ Type of Glasses: Distance Reading
Progressive Bifocal Safety

Do you wear Contact Lenses? Yes No Do you sleep in your contact lenses? Yes No

Contact Lens Solution: _____

Brand/Type of Contact Lenses: _____

Prescription (if known) R: _____ L: _____

Have **you** ever had *any* of the following?			Which Eye	Date(s)	Have **relatives** had any of the following? Who?		
* Cataract Surgery	Yes	No	Right Left	_____	Yes	No	_____
* Laser Surgery	Yes	No	Right Left	_____	Yes	No	_____
* Retinal Detachment	Yes	No	Right Left	_____	Yes	No	_____
* Glaucoma	Yes	No	Right Left	_____	Yes	No	_____
* Eye Injury	Yes	No	Right Left	_____	Yes	No	_____
* Lazy or Turned Eye	Yes	No	Right Left	_____	Yes	No	_____
* Other Eye Surgeries	Yes	No	Right Left	_____	Yes	No	_____

Other Eye Problems: _____

Medical History/ Review of Systems

Please List Drug Allergies or write "No Known": _____

Please List Any Eye-Drops Used (Name Strength & Reason): _____

***Please list medications below with name & strength if known:**

Diabetes:	Yes*	No	_____
High Blood Pressure:	Yes*	No	_____
Endocrine (Thyroid Disease):	Yes*	No	_____
Heart Problems (Irregular, CHF, Surgery):	Yes*	No	_____
Lung/Breathing Problems (Asthma, COPD):	Yes*	No	_____
Gastrointestinal Problems (Reflux):	Yes*	No	_____
Kidney Problems:	Yes*	No	_____
Arthritis:	Yes*	No	_____
Neurologic Problems (Seizure,Migraine):	Yes*	No	_____
Mood Disorders (Depression, Anxiety):	Yes*	No	_____
Blood Disorders (Anemia, Sickle Cell):	Yes*	No	_____
HIV / AIDS:	Yes*	No	_____
Cancer (Type_____):	Yes*	No	_____

Other_____

Do you drive?	Yes	No
Do you smoke?	Yes	No
Do you drink alcohol?	Yes	No
Are you pregnant?	Yes	No

How Did You Hear About This Office? *(Please check all that apply):*
Newspaper Yellow Pages Screening Location Web Site Other:_____