EYE CARE OF DELAWARE LLC

(302) 454-8800
eyecareofdelaware.com

PATIENT REGISTRATION

Last Name	First	MI	Female ☐ Male ☐ Other ☐	Birth Date

Address	Apt #	City	State	Zip Code

Race: White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Indian ☐ Other __________
Ethnicity: Hispanic ☐ Non-hispanic ☐ Prefer not to report ☐
Language: Englist ☐ Spanish ☐ ASL ☐ Other ___________

Please Check Preferred Contact	Home Phone ☐	Cell Phone ☐	Work Phone ☐

Email	Occupation	Marital Status	Live Alone or with someone?

Pharmacy Name & Phone Number	Primary Care Physician & Phone Number

Emergency Contact Name	Emergency Contact Phone	Relationship

Referring Doctor Name	Practice Name	Phone	Last Visit Date
Is this your regular eye doctor?	If NO, who is your regular eye doctor?		Last Visit Date

Reason for today's visit:	Date started:

Location: Right Eye ☐ Left Eye ☐ Both Eyes ☐
Severity: Mild ☐ Moderate ☐ Severe ☐
Quality: Blurry ☐ Foggy ☐ Double ☐ Other ___________

Glasses	Yes	No	If Yes:	How often do you wear?		
Contacts	Yes	No	If Yes:	Soft ☐	Hard ☐	Last Date Worn:

Do you have difficulty with any of these activities, even with glasses?

Driving	☐	Watching TV	☐	Crafts	☐
Reading	☐	Computer use	☐	Other	__________
Writing	☐	Recreational Activities	☐		

Do you drive?	Yes	No	Explain	__________			
Do you drink alcohol?	Yes	No	If yes,	Occasionally	1/day	2-3/day	4+/day
Do you use tobaco?	Yes	No	If yes,	1/2 pack/day	1 pack/day	1+pack/day	
Do you use recreational drugs?	Yes	No	Have you ever had a blood transfusion	Yes	No		
Are you pregnant?	Yes	No					

Patient Name: ______________________________ **Date of Birth:** ____________________

Date of last influenza vaccine: ____________________

Date of last pneumonia vaccine: ____________________

Please list all prior surgeries: ____

____

____

Have you ever been **diagnosed** or **treated** for any of the following conditions?

Cataracts	Yes	No	Corneal Disease	Yes	No	Dry Eyes	Yes	No
Glaucoma	Yes	No	Macular Degeneration	Yes	No	Eye Trauma	Yes	No
Iritis	Yes	No	Retinal Disease	Yes	No	Crossed or Lazy Eye	Yes	No

Do you have a **family** history of any of the following?

Cataracts	Yes	No	Macular Degeneration	Yes	No	High Blood Pressure	Yes	No
Glaucoma	Yes	No	Diabetic Retinopathy	Yes	No	Corneal Disease	Yes	No
Diabetes	Yes	No	Retinal Detachment	Yes	No	Other hereditary?		

I have no medical conditions. Initial here _______

Eyes		
Vision loss	Yes	No
Any changes in vision	Yes	No
Eye pain	Yes	No
Other		

Ears, Nose, Mouth, Throat		
Hearing loss	Yes	No
Sinus problem	Yes	No
Infections	Yes	No
Other		

Respiratory		
Asthma	Yes	No
Bronchitis	gy □ D	No
Shortness of breath	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Other		

Blood		
Anemia (low count)	Yes	No
Excessive bleeding	Yes	No
Bruising easily	Yes	No
Clotting problems	Yes	No
Other		

Genitourinary		
Kidney infections	Yes	No
Urinary infections	Yes	No
Prostate cancer	Yes	No
Other		

Musculoskeletal		
Osteoporosis	Yes	No
Arthritis	Yes	No
Muscle pain	Yes	No
Other		

Integumentary		
Keloid scarring	Yes	No
Rashes, sensitivities	Yes	No
Skin cancer	Yes	No
Breast cancer	Yes	No
Other		

Allergic or Immunologic		
Lupus	Yes	No
HIV	Yes	No
Other		

Psychiatric		
Depression	Yes	No
Psychosis	Yes	No
Mania, bipolar	Yes	No
Schizophrenia	Yes	No
Other		

Neurological		
Seizure	Yes	No
Stroke	Yes	No
Paralysis/weakness	Yes	No
Numbness	Yes	No
Migraines	Yes	No
Other		

Diabetes		
Are you diabetic?	Yes	No
Type 1 Type 2 (circle type)		
When diagnosed?		
On insulin?	Yes	No
Times per day?		
Hgb A1c?	Yes	No
Recent range		
From: To:		
Do you test at home?	Yes	No
On kidney dialysis?	Yes	No
Other		

Cardiovascular		
Heart attack	Yes	No
High blood pressure	Yes	No
Last blood pressure:	Yes	No
Heart murmur	Yes	No
Irregular heart beat	Yes	No
Mitral valve prolapsed	Yes	No
Circulation problems	Yes	No
Other		

Gastrointestinal		
Ulcers	Yes	No
Diverticulitis	Yes	No
Constipation	Yes	No
Hepatitis	Yes	No
Other		

Endocrine System		
Thyroid condition	Yes	No
Other		

______________________________ ____________________

Patient Signature **Date**

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Medication Reconciliation

List all medications you take including prescribed, over the counter, herbal supplements and vitamins. Be sure to include any eye drops that you use. List medication allergies below.

Medication	Dosage	Frequency	To the right of this shaded area is for medical office use only				

Note: If medication is **not** taken orally, please inform the technician at the time of your office visit.

Are you allergic to any medications?: Yes No

List medication allergies: ____

Do you use tobacco? Yes No If yes, ___________ packs /cigarettes per day. Counseled: _____________

Patient Name: ____ Date of Birth: ______________

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Patient Name: ____ **DOB:** ___________________________

PRIVACY AUTHORIZATION NOTICE

I have read the Notice of Privacy Practices and by signing this form consent to the use and disclosure of my protected health information. I have the right to review the Notice before signing this consent and I am aware that terms of the Notice may change.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

Additionally, I authorize the release of information to the following person(s):

Name	Relationship
________________________________	________________________________
________________________________	________________________________

PATIENT CONSENT FOR MEDICAL RECORDS MAINTENANCE

I have read the Eye Care of Delaware, LLC Medical Records Maintenance Policy (included in the Notice of Privacy Practices) and by signing this form consent to this arrangement.

Signature: ____ Date: _______________

EYE CARE OF DELAWARE, LLC OFFICE AND FINANCIAL POLICY

I have read the Eye Care of Delaware, LLC/Cataract and Laser Center, LLC Office and Financial Policy and by signing this form consent to the terms.

Signature: ____ Date: _______________

PATIENT AUTHORIZATION ASSIGNMENT OF MEDICARE/MEDICAID BENEFITS

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center for any service furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare/Medicaid assigned cases, the provider agrees to accept the charge determination of the Medicare/Medicaid carrier and I am responsible for the deductible, co-insurance and/or the 20% Medicare does not pay, and for any non-covered services. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature: ____ Date: _______________

COMMERCIAL/HMO/BLUE SHIELD/SECONDARY INSURANCE

I request that the payment of authorized benefits be made either by me or on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center, for services provided to me. I authorize any holder of medical information about me to release it to my insurer, or any information needed to determine these benefits payable for related services. I am responsible for any insurance deductible, co-insurance, non-covered services and exclusion of benefits. It is my responsibility to obtain any referrals required for services. If a referral was required and not obtained I will be responsible to pay for the services received. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as the original.

Signature: ____ Date: _______________