PARKWAY OPTICAL
PATIENT INFORMATION FORM

PERSONAL INFORMATION

Patient Name:_____Preferred Name:_____

SS#: _____DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#:_____

Email: _____

Preferred Phone#: ❑ Home ❑ Cell ❑ Work Preferred Contact Method: ❑ Text ❑ Email ❑ Phone

Race: _____

Ethnicity:_____

Preferred Pharmacy (include address): _____

Referring Physician:_____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT / SPOUSE / PARENT / RELATIVE INFORMATION

Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Employer: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____DOB: _____

ID #: _____ Group#: _____

Relationship to Subscriber: _____

I certify that the information on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date

*** PLEASE TURN PAGE OVER ***

PARKWAY OPTICAL

Patient Name: _____DOB:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Parkway Optical/Empire Eye and Laser Center. I hereby authorize said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges not paid by my insurance, including non-covered services—such as refraction and cosmetic procedures.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called Protected Health Information (PHI), under a federal health privacy law. I further understand that my PHI may be used to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this authorization at any time by notifying Parkway Optical/ Empire Eye and Laser Center in writing.

I have received a copy Parkway Optical/Empire Eye and Laser Center's **Notice of Privacy Practices** prior to signing this consent.

I understand I have the right to restrict how my PHI is used or disclosed by notifying Parkway Optical/Empire Eye and Laser Center of my wishes in writing.

PATIENT FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.

I understand that I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier, which are not otherwise covered by my primary or supplemental insurance.

PATIENT OPT-IN

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. By requesting a ride, I also consent to be contacted on my phone number on file (including by autodialer) about my trip.

_____ _____

Patient Signature Date

EMPIRE EYE AND LASER CENTER

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name:_____Preferred Name:_____Allergies to Meds:_____

Date of Birth: _____ Sex: M / F Height: _____Weight:_____

Primary MD:_____Referring Doctor:_____Date of Last Eye Exam:_____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE any that apply or "none")

Eyes: None / HSV/VZV Keratitis / Amblyopia

Ear / Nose / Throat: None / Allergies / Dysphagia

Cardiovascular: None / Heart Disease / High Blood Pressure / Atrial Fibrillation

Respiratory: None / Asthma / COPD

Gastrointestinal: None / Hepatitis

Genitourinary: None / Flomax use

Musculoskeletal: None / RA / Arthritis / Lupus / Fibromyalgia

Neurologic: None / Bell's Palsy / Previous Stroke

Psychiatric: None / Depression / Anxiety

Endocrine: None / Thyroid Abnormalities / Diabetes, Year Diagnosed: _____, Last A1C:_____

Immunologic: None / HIV-AIDS

Hematologic: None / Easy Bleeding

General Health: Accutane Use / Cordarone Use

Other:

FAMILY MEMBER WITH THE FOLLOWING:

Y N CATARACTS, Relationship:

Y N GLAUCOMA, Relationship:

Y N DIABETES, Relationship:

DO YOU DO THE FOLLOWING:

Y N SMOKE: Packs/day _____ # of years___

Y N DRINK:

❑ Less than 1 drink/day,

❑ 1-2 Drinks/day,

❑ 3 or more drinks/day

OCCUPATION/WORKPLACE:_____

OCULAR HISTORY / DIAGNOSIS:

❑ Allergic Conjunctivitis ❑ Blepharitis ❑ Cataracts

❑ Corneal Dystrophy ❑ Diabetic Retinopathy

❑ Dry Eyes ❑ Glaucoma ❑ Macular Degeneration

❑ Strabismus ❑ Floaters Other:

HAVE YOU EVER HAD A PROBLEM WITH OUTPATIENT SURGERY OR ANESTHESIA?

(If Yes, Please explain)

❑No / ❑ Yes: _____

SURGERY HISTORY ❑ None

Date Procedure Surgeon

_____

_____

_____

_____

_____

MEDICATIONS (List All): ❑ None

_____

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FOR EELC USE ONLY

OCULAR SURGERIES: ❑ None

Date Procedure Surgeon

_____

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Initials/Date

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STAFF USE, DATE:_____

EMPIRE
EYE & LASER CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ **Date of Birth**: _____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

I authorize Empire Eye and Laser Center (EELC) to discuss my PHI with the following individuals. This may include information about my appointments, diagnoses, and treatments.

Name:_____DOB:_____

Phone:_____Relationship:_____

Name:_____DOB:_____

Phone:_____Relationship:_____

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless otherwise specified. I may revoke this authorization at any time by notifying EELC in writing. My revocation will not affect actions taken by EELC prior to its receipt.

I understand that once the information is disclosed, it may be re-disclosed by the recipient; federal and/or state privacy laws may or may not protect the re-disclosure. I understand that authorizing the disclosure of information identified above is voluntary, and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

I have had the opportunity to read and to consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____	_____	_____
Patient/Authorized Signature	Printed Name (If not patient, indicate relationship)	Date