PARKWAY OPTICAL / EMPIRE EYE AND LASER CENTER
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: ____

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 / EMPIRE EYE AND LASER CENTER

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

PARKWAY OPTICAL / 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			Initials/Date
OCULAR SURGERIES:		❑ None	
Date	Procedure	Surgeon	

STAFF USE, DATE:____________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____ **Date of Birth**: ___________________

Address: ____

City:____________________________________ **State:**________________ **Zip Code:**__________________

☐ I have no individuals I want Empire Eye and Laser Center to discuss my PHI with at this time.

☐ 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