EUGENE EYE CARE

PATIENT REGISTRATION

Patient Name(**as shown on insurance card)**: _____
First MI Last

Address: _____
Street or P.O. Box City State Zip

Birthdate:_____ Age:_____ Social Security #_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed - Sex: ☐ M ☐ F ☐Other - Preferred Pronouns: _____

Please indicate which method you would prefer for future appointment reminders - ☐ **Call** ☐ **Text**

Landline: (____) _____ Cell Phone: (____) _____

Email: _____

Patient's Occupation:_____ Employer: _____ Work#:(___)_____

Referred by Doctor:_____ Primary Care Physician:_____

Emergency Contact:_____ Relationship:_____ Contact#:(___)_____

If you are NOT the policy holder please provide their information:

Name:_____ Birthdate:_____Social Security#_____

If you don't feel comfortable providing the full social security number for the policy holder please provide the last four digits. They are often needed to verify insurance

Responsible Party (The person who is responsible for the bill after the insurance has been paid)

☐ Self (If same as above, skip this section) ☐ Responsible Party

Name:_____ Relationship:_____ Contact #: (___)_____

Address:_____
Street or P.O. Box City State Zip

Birthdate: _____ Age: _____ Social Security # _____

Occupation: _____ Employer: _____ Work #:(___)_____

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA). The notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office. Your signature on the bottom of this page affirms that you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that you have the opportunity to review this notice.
- The Practice has a right to change the Notice of Privacy Policies.
- You may revoke this Consent in writing at any time.

PERMISSION TO DISCLOSE HEALTH INFORMATION

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so. Please list the individuals below who have your permission to share healthcare information.

Name	Relationship to Patient	Any Restrictions?

When necessary, I authorize the release of **all personal health information** to any listed recipient ***except*** the following information: (Initial all that apply)

_____ Mental Health
_____Alcohol/Drug abuse treatment
_____Communicable diseases (including HIV and AIDS)
_____ Other (please specify):_____

_____Initial here if you acknowledge the following statement: It is my understanding that without vision coverage through my insurance there will be an out of pocket cost of $65 for refraction. I also understand a refraction is what allows me to receive my glasses and/or contact lens prescription. (This applies to all Medicare plans)

I hereby authorize Eugene Eye Care Associates to furnish to my insurance company, employer, their representatives, or referring party any necessary information concerning my examination or treatment. I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished during the effective period of this authorization. I also request payment of government benefits either to myself or to the party who accepts the assignment. My signature also gives my consent regarding the Notice of Privacy Practices listed above which complies with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

Signature:_____ Date:_____

EUGENE EYE CARE

PATIENT QUESTIONNAIRE

Welcome! We are looking forward to your visit. In order to make the most of your time with us, please fill out this questionnaire. In doing so, you will help us to better understand your vision, health, and lifestyle.

Name:_____ **DOB:**_____ **Age:**____ **Date:**_____
Primary Care Provider:_____
How did you find us?
☐ I was referred by Dr._____ ☐ Word of mouth ☐Other:_____

What is the main problem that we can help you with?
☐ Poor vision ☐Redness ☐Pain ☐ Routine visit
☐Other: _____

Which eye is affected?
☐ RIght eye ☐Left eye ☐Both eyes

How long has the issue been going on?
_____

Tell us about yourself
Occupation:_____

Hobbies: _____

Tell us about your vision
☐ I do not wear glasses ☐ I have been wearing glasses since age:_____
☐ I do not wear contacts ☐ I am interested in contacts
☐ I have been wearing contacts since: _____

My last eye exam was: _____ by Dr. _____

Your Eye History
☐ I have no known eye problems
☐My known medical eye problems are listed below (cataract, glaucoma, macular degeneration, etc):
_____

_____
☐My prior eye surgeries are listed below:
_____

_____

Your Eye Drops ☐None

Please list the eye drops you take, how often, and in which eye:_____

_____

Your Health ☐None

List your known medical problems and previous surgeries:_____

_____

_____

Your Medications ☐None

List the medicines you take daily:_____

_____

_____

Your Allergies ☐None

List any allergies to medications:_____

_____

Your Preferred Pharmacy

List where you would like to receive your prescriptions:

_____

Family History

Check the following conditions present in your family, if any:

☐ Glaucoma ☐ Macular degeneration ☐ Strabismus ☐None

Head to Toe Review

All of the problems below are associated with eye problems. Please check any you are currently experiencing:

General:	☐Fever	☐Weight change	☐Cancer	
Eyes:	☐ Glare	☐ Pain	☐Redness	☐Blur
Head:	☐Stroke	☐Anxiety	☐Headache	☐Depression
Heart:	☐Heart attack		☐Cholesterol	☐Blood pressure
Lungs:	☐Asthma	☐COPD	☐Current smoker	☐Former smoker
Stomach:	☐IBS	☐Diarrhea		
Urinary:	☐Have used Flomax (tamsulosin), doxazosin, or other urinary medications			
Joints/Muscles:	☐Fibromyalgia		☐Rheumatoid	
Skin:	☐Rosacea	☐Lupus	☐Psoriasis	☐Allergies
Endocrine:	☐Thyroid	☐Diabetes		
Blood:	☐Clotting	☐Bruising	☐Bleeding	

☐ **None of these apply to me**

Thanks! We appreciate the time you spent filling out this questionnaire, and we are looking forward to your upcoming visit!

-Your Eugene Eye Care team-

"Our attention is focused on you."

ADVANCED EYE CARE EUGENE EYE CARE

Eugene: 992 Country Club Rd, Ste 101 Eugene, OR 97401 (541) 687-1715
Springfield: 1110 18th St, #3 Springfield, OR 97477 (541) 726-6447
Cottage Grove: 315 S. Pacific Hwy Cottage Grove, OR 97424 (541) 942-0176

Acct: _____

Text and Email Communication

Patient Name: _____ DOB:_____

Mobile Phone #:_____ Email:_____

We have recently acquired a new messaging system for our reminder calls and text messages, and in doing so we are obligated by recent federal law changes to obtain your signed consent to continue communicating via text, email, or automated call.

Vital Interaction will have already sent you a reminder text for your appointment with the option to "opt in" for text communication in the future. If you did not receive or respond to that message but would still like to opt in, please check the box below. If you would like to **opt OUT,** leave it blank.

☐ Yes, I would like to **OPT IN** to text message reminders for my future appointments.

By providing your mobile phone number and email to Eugene Eye Care/Advanced Eye Care, you are agreeing to be contacted by or on behalf of the Clinic by our business partner, Vital Interaction, Inc. Contact includes emails, text messages, calls to your mobile phone or other wireless devices, as well as the use of an automatic telephone dialing system, artificial voice and pre-recorded messages for the purpose of providing clinic services (i.e.; administration, billing, and debt collection). Text communication is unencrypted and does come with inherent risk of inadvertent disclosure, but we will never intentionally share the information provided to any third party. We may share data with trusted partners to help us provide clinical services (Pharmaceutical companies, other healthcare providers, and insurance providers), and all such third parties are prohibited from using your personal information except to provide these services and are required to maintain the confidentiality of your information. We will disclose personal information, without notice, only if required to do so by law.

You may opt out of receiving text messages from the Clinic or its business partners at any time by replying with the word STOP from the mobile device receiving the messages. Consenting to receive notifications is not a requirement for you to receive care at our practice. However, by opting out of this you are acknowledging that this may impact your experience with any service(s) which rely upon communications via text messaging or email.

Please sign below to indicate that you have read and understood the information provided.

Patient's Signature: _____ Date: _____

Relation to Patient: _____