PATIENT INFORMATION

Name ________________________ Tel ____________ ☐ Male ☐ Female
First MI Last

Address ________________________ City/State/ZIP ________________________

Date of Birth __________ Age _____ Social Security # __________ Email ________________

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Minor

Race ______________ Ethnicity ______________ Preferred Language ________________

Emergency Contact Name ______________ Tel ____________ Relationship to you __________

How did you hear about us?: ☐ Friend ☐ Physician ☐ Yellow Pages ☐ Internet ☐ Other ____________

Primary Care Physician ________________ Referring Physician ________________

Pharmacy Name and Location ________________________________

Insurance Information

(Please provide us with a copy of card)

Primary Insurance ________________ Policy ID #: ________________

Policy holder SS#: ________________

Secondary Insurance ________________ Policy ID #: ________________

Guarantor Information

☐ Check here if patient is financially responsible. If not, please provide the following information.

Name ________________________________
First MI Last

Address ________________________ City/State/ZIP ________________________

Social Security #: ________________ Date of Birth ________________

CONSENT AND AUTHORIZATION FOR TREATMENT/ FINANCIAL RESPONSIBILITY /ASSIGNMENT OF BENEFITS

I hereby give my permission and consent for Triangle Eye Physicians, P.A. and staff to treat me using generally accepted standards of medical care, which may include dilation. I am aware and have been informed that the dilation can and will effect my vision. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition (s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete or misleading information. I certify that the identifying information, address, and telephone information have been provided is correct and agree to inform Triangle Eye Physicians, P.A. and staff if such information changes or becomes outdated. I understand that Triangle Eye Physicians, P.A. and staff cannot contact me if I have provided incorrect or illegible information should I not keep this information current and correct. I understand that I am financially responsible for all charges for services rendered to me by Triangle Eye Physicians, P.A.

To: Insurance Carrier/Supplemental Insurance/ Third-Party Payer In consideration of service rendered by Patricia Smith, M.D., their agents and staff, I hereby assign to Triangle Eye Physicians, P.A. the benefits due to me under my health insurance plan. I agree that I shall be responsible for all portions of payments due to Triangle Eye Physicians, P.A. for services received that are not covered by the above such as annual deductible, co-payments, and co-insurance. I agree that I shall be solely responsible for the entire bill for services or any balance thereof that may be determined to be not covered by my health plan. This assignment of benefits shall remain in effect, even if my insurance carrier changes, until revoked in writing.

________________________ ________________________ ____________
Printed Name / Power of Attorney Patient's Signature / Power of Attorney Date

Your Medical, Surgical, Family and Personal History

Patient Name: ______________________ Date: ______________________

Personal History

Have you ever smoked? ☐ Yes ☐ No
Do You Drink Alcohol? ☐ Yes ☐ No
Recreational Drug Use? ☐ Yes ☐ No
Hearing Impaired? ☐ Yes ☐ No

Ocular History (check all that apply for self)

Date of Last Eye Exam? ______________________

☐ Decrease in Vision
☐ Discharge from Eyes
☐ Eye discomfort
☐ Keratoconus
☐ Itchy or Dry eyes
☐ Flashes of light or floaters
☐ Double Vision
☐ Macular Degenerations
☐ Red Eyes
☐ Retinal Detachment
☐ Cataracts
☐ Amblyopia (lazy eye)
☐ Glaucoma

Medical History (check all that apply for self)

☐ Arthritis
☐ Migraine
☐ Emphysema
☐ Stroke
☐ Colitis
☐ Thyroid Disease
☐ Hypertension
☐ Skin condition
☐ Heart Disease
☐ High Cholesterol
☐ HIV
☐ Cancer
☐ Diabetes
☐ Lupus
☐ Chrohn's Disease
☐ Blindness
☐ Dementia
☐ Bruise/Bleed Easily

☐ Other: ______________________

Family History (label as the following if applicable: F for father, M for mother, S for sibling, G for grandparent)

☐ Arthritis
☐ Migraine
☐ Emphysema
☐ Stroke
☐ Colitis
☐ Thyroid Disease
☐ Hypertension
☐ Skin Condition
☐ Heart Disease
☐ High Cholesterol
☐ HIV
☐ Cancer
☐ Diabetes
☐ Lupus
☐ Chrohn's Disease
☐ Blindness
☐ Dementia
☐ Bruise/Bleed Easily

☐ Other: ______________________

Surgical History (List all Past Surgeries: including Eye Surgery with dates)

Surgery: ______________________ Date: ______________________
Surgery: ______________________ Date: ______________________
Surgery: ______________________ Date: ______________________

Current Medications

☐ NONE

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____
____
____

Drug Allergies & Reactions

☐ NONE

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____
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HIPAA Authorization for Release of Information

Name of Patient: ______________________________ Date of Birth: ______________________________

Release of Information

☐ I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. Entity to Receive Information (*Provide Name and relationship of person(s) subject to this authorization*)**:**

- ☐ Spouse: ______________________________
- ☐ Family *(provide their relation)*: ______________________________
- ☐ Others: ______________________________

☐ Information is not to be released to anyone.

Description of Information to be released (check mark that is subject to this authorization):

- ☐ Financial Information – Person(s) Name: ______________________________
- ☐ Medical Information – Person(s) Name: ______________________________
- ☐ Other Information as Described & whom is to receive the information:

____

Please check below with your permission:

☐ I do ☐ do not want to leave information on my or person(s) voice mail/answering machine
☐ I do ☐ do not authorize information to be released for the purpose of marketing

AUTHORIZATION TO RELEASE PATIENT RECORDS TO INSURER

I hereby authorize Triangle Eye Physicians, P.A. to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses for care provided, as is required by North Carolina Insurance Regulations. I understand that this authorization allows Triangle Eye Physicians, P.A. to release to my insurer or financial payer any information concerning me, including but not limited to confidential information, financial records, and the records of any treatment or examination rendered me. I understand that this release, and any future general release that I may sign, specifically allows for the release of information to my insurer or financial payer concerning HIV test results and/or related data that may be a part of my medical records. This general release and authorization shall remain in effect until revoked by me in writing.

I understand that I have the right to revoke this authorization at anytime in writing, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to: Triangle Eye Physicians, P.A.I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Acknowledgement of Receipt

A copy of the Notice of Privacy Practice from Triangle Eye Physicians, P.A. has been made available to me.

______________________________ ______________________________________ ________________
Printed Name / Power of Attorney   Patient's Signature / Power of Attorney   Date