METRO EYES

Doctors of Optometry and Ophthalmology

PATIENT NAME: (Last, First) _____	**DATE OF BIRTH** (month/day/year)**:** **SSN #:** _____/_____/_____ _____-_____-_____
SEX (circle one): *Female* *Male* *Other*	**MARITAL STATUS** (circle one)**:** *Single* *Married* *Divorced* *Widowed*
PHONE NUMBER:	**EMAIL ADDRESS:**
STREET ADDRESS: **CITY:** **STATE:** **ZIP CODE:** _____	
LEGAL GUARDIAN #1 (if the patient is a minor)**:** Name (Last, First):_____ Date of birth (month/day/year): _____/_____/_____ SSN # :_____-_____-_____	**LEGAL GUARDIAN #2** (if the patient is a minor)**:** Name (Last, First):_____ Date of birth (month/day/year): _____/_____/_____ SSN #:_____-_____-_____
MEDICAL INSURANCE INFORMATION	**VISION INSURANCE INFORMATION**
POLICY NAME: _____ POLICY ID #: _____	POLICY NAME: _____ POLICY ID #: _____
POLICYHOLDER INFORMATION	**POLICYHOLDER INFORMATION**
Name (Last, First):_____ Date of birth (month/day/year): _____/_____/_____ Sex (circle one): *Female* *Male* *Other* SSN # :_____-_____-_____ Relationship with patient: _____	Name (Last, First):_____ Date of birth (month/day/year): _____/_____/_____ Sex (circle one): *Female* *Male* *Other* SSN # :_____-_____-_____ Relationship with patient: _____

The undersigned patient, legal guardian, or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Metro Eyes to render needed treatment to the patient above.
2. Permission is granted for Metro Eyes to send medical records or prescriptions electronically with consent.
3. Permission is granted for Metro Eyes to release information regarding medical treatment, rendered to the above named patient to any insurance company, employer or referring physician.
4. I understand that if I do not have vision coverage, or am not eligible for a vision exam, I am responsible for a referral from my primary care physician.
5. I understand that most insurance policies only pay a portion of my total charges.
6. If I have any questions about my coverage, I will contact my insurance representative.
7. Metro Eyes does not guarantee the accuracy of benefit information given.
8. I understand that the financial responsibility of my account is mine, not the responsibility of my insurance company.
9. I understand that I am responsible for any balance my insurance company does not pay.I authorize the release of any medical information or other information necessary to process insurance claims.
10. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment.

Signature of patient, legal guardian, or individual acting on behalf of patient: **Date:**

_____ _____/_____/_____

REVIEW OF SYSTEMS	YES	NO
Do you have allergies to any medications:	❑	❑
Constitutional (fever, weight loss, other)**:**	❑	❑
Eyes (glaucoma, cataract, lazy eye, retinal problems)**:**	❑	❑
Ears/Nose/Throat (hearing loss, sinus problems, sore throat)**:**	❑	❑
Cardiovascular (heart problems or condition, chest pain)**:**	❑	❑
Respiratory (shortness of breath, wheezing, coughing)	❑	❑
Gastrointestinal (heartburn, abdomen pain, diarrhea, vomiting)**:**	❑	❑
Genitourinary (urinary problems, blood in urine)**:**	❑	❑
Integumentary (skin rashes, excessive dryness)**:**	❑	❑
Musculoskeletal (muscle aches, joint pain, swollen joints)**:**	❑	❑
Neurological (numbness, weakness, headaches, paralysis)**:**	❑	❑
Hematological/Lymphatic (blood disorders)**:**	❑	❑
Allergic/Immunologic (hay fever)**:**	❑	❑
Endocrine (thyroid disease)**:**	❑	❑
Psychiatric (depression, anxiety)**:**	❑	❑

1. If you checked “yes” to any of the above conditions, please explain:

_____

2. Please list any medications you are taking:

_____

3. If you have conditions that were not previously addressed, please list them:

_____

Do you have high blood pressure? (Please circle one).

YES *NO*

Have you been diagnosed with diabetes? (Please circle one).

YES *NO*

Have you been diagnosed with glaucoma? (Please circle one).

YES *NO*

Have you been diagnosed with macular degeneration? (Please circle one).

YES *NO*

Do you drink alcohol? If yes, how much? (Please circle one).

YES *NO*

_____

Do you smoke? If yes, how much? (Please circle one).

YES *NO*

_____

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient 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. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Metro Eyes has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Signature of patient, legal guardian, or individual acting on behalf of patient: **Date:**

_____ _____/_____/_____