East Carolina Center for Sight

Patient and Responsible Party Information **Acct #** ____________

____ DOB ______________

First Name Last Name Middle

Address ____________________________ City __________________ State ___ ZIP ________

Home Phone# ____________________ Work # __________________ Cell # _________________

SS # ____________________ Sex _______ Race ___________ Marital Status _______________

Emergency Contact ______________________________ Phone # ________________________

Is the eye problem a result of employment? YES/NO Date of injury/illness ____________________

Employer ____________________________________ Phone # ____________________________

Address __________________________ City ________________ State ____ Zip _____________

Insurance Information

Primary: ____________________ Policy Holder: _______________________ DOB: ____________

ID # __________________________ SS#: _____________________

Secondary: __________________ Policy Holder: _______________________ DOB: ___________

ID# _______________________ SS#: _______________________

Acknowledgment

I agree that unless East Carolina Center for Sight and my insurer have a prior agreement I am personally responsible for all non-covered services, co-pays and deductibles. I (we) hereby agree to pay for services rendered to the above mentioned patient as incurred.

Signature ________________________________ Date ________________________

I authorize payment of Medical Benefits to East Carolina Center for Sight. I authorize release of any medical information necessary to process the claim, and/or I also request payment either to myself or party who accepts assignment.

Signature ________________________________ Date ________________________

Please provide receptionist with a copy of your ***insurance card(s)*** and ***drivers' license.***
Thank You.

Name:_________________________ Chart#_________________________

PCP_________________________ Referring MD_________________________

Medications

_______________ _______________ _______________
_______________ _______________ _______________

Surgeries

_______________ _______________ _______________

Allergic to: ☐ Penicillin/Amoxicillin ☐ Sulfa ☐ Aspirin ☐ Latex ☐ None Known
☐ Other:_________________________

Medical History If you have ever had or have any of these problems please check the box next to it, If you have not had or have any of these conditions please check **No Problems**

Eyes, Ears, Nose, Throat	**Endocrine**	**Cardio**	**Neurology**
☐ Cataracts	☐ Diabetes	☐ Heart Attack	☐ Stroke
☐ Glaucoma	☐ Hyperthyroidism	☐ High Blood Pressure	☐ Seizures
☐ Diabetic Retinopathy	☐ Hypothyroidism	☐ Congestive Heart Failure	☐ MS
☐ Iritis	☐ High Cholesterol	☐ Angina	☐ Head Inury
☐ Retinal Detachment	☐ **No Problems**	☐ Stents	☐ Headaches
☐ Macular Degeneration		☐ Heart Disease	☐ Weakness/Numbness
☐ Impaired Vision	**Hematologic/Oncologic**	☐ Pacemaker	☐ **No Problems**
☐ Wear Glasses or contacts	☐ Sickle Cell	☐ Chest Pain	
☐ Ear problems	☐ Leukemia	☐ Heart Murmur	**Musulo-Skeletal**
☐ Nose problems	☐ Anemia	☐ Palpitations	☐ Rheumatoid Arthritis
☐ Seasonal Allergies	☐ Tumor, Cancer cyst	☐ **No Problems**	☐ Osteoporosis
☐ **No Problems**	☐ Bleeding Disorder		☐ Fibromyalgia
	☐ **No Problems**	**Respiratory**	☐ Back Pain
Genitourinary		☐ Asthma	☐ **No Problems**
☐ Kidney Disease	**Psychiatric**	☐ COPD	
☐ Incontinence	☐ Schizphrenia	☐ Emphysema	**Immunologic/Infectious Disease**
☐ Prostate problems	☐ Depression	☐ Chronic cough	☐ HIV/AIDS
☐ **No Problems**	☐ Anxiety	☐ Shortness of Breath	☐ Hepatitis
	☐ Dementia	☐ **No Problems**	☐ Tuberculosis
Gastrointestinal	☐ **No Problems**		☐ Lupus
☐ Acid Reflux			☐ **No Problems**
☐ Ulcers			
☐ **No Problems**			

Family History (Please check the box if any of your family members have or had any of these conditions)
M-Mother **F-**Father **S-**Sibling **GP-**Grandparent **Fam-**Family

Cancer	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None	Glaucoma	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None
Diabetes	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None	Heart Disease	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None
Cataracts	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None	Retinal Disease	☐ M	☐ F	☐ S	☐ GP	☐ Fam	☐ None

Social History

Occupation_________________________ Hobbies _________________________

Live Alone? ☐ Yes ☐ No if No, please check: ☐ Nursing Home ☐ Group Home

Do you drink? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

FEMALE: Pregnant? Yes No Breast Feeding? Yes No

EAST CAROLINA CENTER FOR SIGHT

Acct# ______________

NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with this notice and to maintain the privacy of your health information as outlined herein.

We will not disclose your health information to anyone without your prior written authorization except as required by law in the following situations:

- An FDA request for information on adverse effects.
- A public health agency request for information to prevent epidemics, disease, or a threat to public safety.
- To report abuse, neglect, or domestic violence.
- To comply with an audit of healthcare delivery performed by government agencies such as Medicare
- Under court order or subpoena.
- To cooperate with law enforcement official or the medical examiner in the investigation of a crime

You have the right to:

- Request restrictions on the health information we disclose.
- Inspect or copy your health information.
- Request us to amend your health information.
- Request we contact you only according to your specific instructions.
- Receive an accounting of disclosures of your health information.
- Revoke the authorization(s) indicated below.

All requests must be in writing to **East Carolina Center for Sight.**

If you believe your privacy rights have been violated, you may file a complaint with the secretary of the Department of Health and Human Services.

I authorize **East Carolina Center for Sight** to release my health information to:

____________________________________ ____________________________________

Person or entity Relationship

____________________________________ ____________________________________

Person or entity Relationship

____________________________________ ____________________

Patient Signature **Date**