PATIENT REGISTRATION

artisan EYEWORKS

Office Use Account # _____

Today's Date _____

PATIENT INFORMATION

Patient Name: _____ Age: _____ DOB: _____ SSN: _____

Gender: ◯F ◯M Marital Status: ◯Single ◯Married ◯Other If Married, Spouse Name: _____

Address: _____ City: _____

State: _____ Zip : _____ Phone: _____ Can we text? ◯Y ◯N

Email: _____

HEALTH HISTORY

Do you wear glasses? ◯Y ◯N If yes, how old is your current pair? _____

Types of lenses worn: ◯Distance ◯Readers ◯Bifocal ◯Trifocal ◯Progressives

Do you wear contacts? ◯Y ◯N If yes, Brand? _____

Types of lenses worn: ◯Rigid ◯Soft ◯Extended Wear ◯Other _____

Do you now or have you ever had *(select all that apply)*:

☐Eye Injury	☐Macular Degeneration	☐Strabismus (eye turn)
☐Eye Surgery or LASIK	☐Glaucoma	☐Vision Therapy
☐Cataracts	☐Lazy Eye (amblyopia)	☐Keratonconus

☐Other _____

List any eye drops you are currently using: _____

List all medications:

Allergies to medications:

Has a family member ever been diagnosed with glaucoma? ☐Mother ☐Father ☐Sibling ☐None

Has a family member ever been diagnosed with macular degeneration? ☐Mother ☐Father ☐Sibling ☐None

Please check all of the following that apply to you only:

☐Cancer	☐Diabetes (Type: _____)	☐Radiation/Chemo (in the last 6 mos)
☐Thyroid Dysfunction	☐Stroke	☐Lupus
☐Seizures	☐Sjogren's Syndrome	☐High Blood Pressure
☐Rheumatoid Arthritis	☐Heart Disease	☐High Cholesterol
☐Asthma	☐Anemia	☐COPD
☐MS	☐Crohn's	☐Hearing Loss
☐Colitis	☐Dry Mouth	☐Arthritis
☐Depression	☐Osteoporosis	☐Anxiety
☐Shingles (currently or in the past)	☐Kidney Disease	

SOCIAL HISTORY

Do you use tobacco? ◯Yes ◯No ◯Never Do you drink alcohol? ◯Yes ◯Occasionally ◯No

Do you drive? ◯Yes ◯No If yes, do you have visual difficulty while driving? ◯Yes ◯No

On average how many hours per day are you in front of a screen? _____

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DOB _____

CONSENT TO TREAT

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any findings, the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and you are subjected to their specific co-pays, deductibles, and co-insurance which will be due at the time of service. In the event you want a routine examination for your eyeglasses or contact lens prescription, you understand it is your responsibility to immediately inform the Doctor so that they can refer you to the appropriate Specialist for any medical concerns.

Initials _____

FINANCIAL ACKNOWLEDGMENT

I hereby authorize the practice to release information to any of my insurance companies when necessary to complete my claim. I understand that I am financially responsible for items not covered by my insurance such as co-payments, deductibles, denied items, and non-covered services. Except for items filed to insurance, payment is required at the time services are provided unless other arrangements have been made in advance. I authorize the practice to deposit checks received on my account made out to me for services rendered. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at the time of service does not guarantee payment and any denied services will be balanced and billed to the patient.

Patients with insurance must present their information to us prior to any service(s)/purchase(s). We will not bill the insurance after the service(s)/product(s) are already performed, therefore there will be no refund! You may send the receipt to your insurance company and try to get reimbursed yourself. In the case that a return is needed, there will only be store credit. No monetary refund will be given.

Initials _____

HIPAA COMPLIANCE AND RELEASE OF INFORMATION

This practice is committed to protecting your personal medical information. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and complies with this office's medical release retention requirements. This notice applies to the medical records maintained by this office and it specifically details the ways in which your medical information may be used and disclosed to third parties. This notice also details your individual rights regarding your medical records.

This office may use and/or disclose your medical information consistent with valid consent granted by you for the purpose of:

a. **Treatment:** In order to provide you with the healthcare you require, this office will provide your medical information to those healthcare professional.
b. **Payment:** In order to get paid for services provided, this office will provide your medical information, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
c. **Healthcare Operations:** In order to gain an overall view of various elements of this office's operations, individual medical information may be collected, compiled, and disseminated.

Access to the practice's complete Notice of Privacy Practices is available on our website or in person at the practice.

Initials _____

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Patient Name _____

DOB _____

RELEASE OF HEALTH INFORMATION AUTHORIZATION

I grant permission to the practice to release my private health information to the persons listed below. I understand my information will not be released without my written consent.

NAME	RELATIONSHIP	PHONE NUMBER

COMMUNICATION AUTHORIZATION

I agree to receive messages from the practice in the forms I have indicated below for appointments and practice updates. I understand that I will be responsible for any fees that my mobile carrier(s) charges for receiving such messages, and I may withdraw my consent to receive messages from the practice at any time by notifying the practice in writing. **Note:** Your email, phone, and other information is protected—we will never share it.

I would like to receive messages via: ◯ Email ◯ Text Messages ◯ Phone Calls _____ *Initials*

CONSENT OF ACKNOWLEDGMENTS

I have read the above authorizations as the patient, the patient authorized representative, or general agent for the purpose of signing this document, hereby accept its terms.

Patient Name Printed: _____ Date Signed: _____

Patient/Guardian Signature: _____