PATIENT DEMOGRAPHIC FORM

(to be filled out in order to be seen by Dr. Rowe)

Today's Date _____

Patient Name: _____ Marital Status: □Single □Married □Other

Date Of Birth: _____ Sex: □M □F Social Security Number: _____

Address: _____ City: _____ State: _____ Zip_____

Home Phone: _____ Work/Daytime Phone: _____ Cell Phone: _____

Email: _____

Employment Status : □Full-Time □Part-Time □Full-time Student □Not Employed □Retired

Employer: _____ Position: _____

Preferred Language : □English □Spanish □Other

Race : □American Indian or Alaska Native □ Asian □Black/African American □Hispanic
□ Native American □Other Pacific Islander □ White

Ethnicity : □Hispanic or Latino □Native Hawaiian/Other Pacific Islander □Not Hispanic or Latino

Communication Preference : □Email □Standard Mail □Text □Telephone

Primary Care Physician: _____ Phone Number: _____

Insurance Information

Name of Vision Insurance : _____

Member ID Number: _____ Group Number: _____

Insurance Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Employer: _____ Work Phone: _____

Name of Medical Insurance : _____

Member ID Number: _____ Group Number: _____

Insurance Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Employer: _____ Work Phone: _____

Do you have Secondary Medical/Vision Insurance? □YES □NO

Name of Secondary Insurance: _____

Member ID Number: _____ Group Number: _____

Insurance Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Employer: _____ Work Phone: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____ DOB: _____ Social Security Number: _____

Relationship to Patient: _____ Work/Daytime Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Social and Preventative History:

Do you Currently Smoke or Chew Tobacco? □YES □ NO If NO, how many years since you stopped?_____

How Many packs per day? _____ How Many years have you smoked? _____

Do you drink alcohol, beer, or wine? □YES □NO How Many drinks per week? _____

Narcotic Use: □NONE □ Recreational Use □Chemical Dependence

Blood Transfusion: □YES □NO **Sexually Transmitted Disease:** □YES □NO □HIV Positive

Personal Medical History (check all that apply):

Diabetes: □YES □NO Hypertension(High Blood Pressure): □YES □NO Heart Attack: □YES □NO

Heart Murmur: □YES □NO Congestive Heart Failure: □YES □NO Stroke: □YES □NO

Emphysema: □YES □NO COPD: □YES □NO Arthritis: □YES □NO

Bleeding Disorder: □YES □NO Anemia: □YES □NO Asthma: □YES □NO

Depression: □YES □NO Anxiety: □YES □NO Migraine Headaches: □YES □NO

Seizure Disorder: □YES □NO ADHD/ADD □YES □NO Kidney Disease: □YES □NO

Liver Disease: □YES □NO Thyroid Disorder: □YES □NO Breast Cancer: □YES □NO

Colon Cancer: □YES □NO Skin Cancer: □YES □NO Prostate Cancer: □YES □NO

Other: _____ Other: _____

Surgeries? □YES □NO IF yes, what kind and when? _____

_____

Current Medications: _____

_____

_____

Allergies to Medications? □YES □NO If yes, Name of Medication and Reaction _____

_____

Eye Health History:

What are you Currently Wearing?

□ Full Time
□ Glasses for distance only
□Glasses for reading only
□Bifocals □ Trifocals/Progressives
□Contact Lenses

Are you interested in:

□New Glasses
□Contact Lenses
□Laser Vision Correction

Do you have any of the following:

□Cataracts □Crossed or Lazy eye □Macular Degeneration □Glaucoma □Eye Strain

□Color Vision Problems □Blurred Night Vision □Double Vision □Dry Eyes □Eyes Water

□Red Eye □Eye pain □ Itchy eyes □ Seeing Spots □Blurry Near Vision □ Blurry Vision at Distance

□ Flashes of Light □Watery Discharge □Thick Discharge □Temporary Vision Loss

Have your parents or siblings had any of the following? If so, Relationship:_____

□Glaucoma □Macular Degeneration □Loss of Vision □ Retinal Detachment □Diabetic Eye Disease

Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes theses uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary for appropriate for you to receive the follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination for benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office. You also consent to our submission of your health care information to other health care providers for the continuation of care discussed between the patient and Dr. Rowe for services that cannot be performed here in our office.

When you sign this consent document, you signify that you agree that we can and will disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosure made for purposes of treatment, payment or health care operations, but as described in our ***Notice of Privacy Practices***, we are not obligated to agree to these suggested restrictions; unless you are paying for these services privately. If we do agree, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for restriction.

Insurance Non-Covered Services Notice

Private insurance will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If your insurance company determines that a particular service or treatment is "not reasonable and necessary" under Medicare program standards, then they will deny payment for that service or treatment unless explicitly stated that the service or treatment would be otherwise covered. Under these circumstances, these charges are the patient's responsibility. Please refer to your insurance coverage documents for detailed information.

I have read this document and understand it. **I consent to the use of disclosure of my health information for purposes of treatment, payment, and health care operations.** I acknowledge that I have received the ***Notice of Privacy Practices***. I understand that my insurance company may not cover all services billed. I understand that verification of benefits is not a gurantee of payment by my insurance. I agree to be personally and fully responsible for any charges related to the services that the insurance company has denied payment for.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Patient

Source of Authority: _____