Lifetime Eye Care Patient Registration Form

Name: _____ Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Sex ☐ M ☐ F Marital Status ☐ Married ☐ Single ☐ Other

Home Phone: _____Cell Phone: _____Work phone: _____

Email: _____Last 4 of Social: _____

Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Do you wear glasses? ☐ Y ☐ N Contact Lenses? ☐ Y ☐ N

Would you like Text Notifications? ☐ Y ☐ N

Are you interested in Contact Lenses today? ☐ Y ☐ N

Reason for today's appointment: _____

Are you using insurance for today's appointment? ☐ Y ☐ N

Vision Insurance Company: _____ Medical Insurance Company: _____

Primary Insured's Name, D.O.B., and Last 4 of their Social: _____

Primary Insured's Place of Work:_____

Eye History

Diagnosed with any eye conditions? (*what and when*) _____

Any eye conditions run in the family? (*what and relationship*) _____

Medical History:

Name of Primary Care Doctor and Facility: _____

Do you have any problems with any of these systems? **(*check all boxes that apply)***

☐ Gastrointestinal ☐ Nervous ☐ Eyes ☐ Endocrine ☐ Ears/Nose/Throat ☐ Kidney

☐ Musculoskeletal ☐ Mental ☐ Skin ☐ Headaches ☐ Allergic / Immune ☐ Lung

☐ Genitourinary ☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes Type ☐ I ☐ II

Other Health Problems: _____

Do you use cigarettes/tobacco? ☐ Y ☐ N Do you use Alcohol? ☐ Y ☐ N Other Substances ☐ Y ☐ N

Medications: _____

_____

Medication Allergies: _____ Seasonal Allergies ☐ Y ☐ N

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Throughout 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 to treat you, to obtain payment for our services, and to conduct health care operations.

When you sign this document, you signify that you agree and allow us to use and disclose your health information for the purposes of treating 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, written in plain language. The notice provides in detail the uses and disclosures of your protected health information that may be made by this practice, your individual rights, how you may exercise these rights, and the practice's legal duties with respect to your information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me with a copy of the revised Notice of Privacy Practices, upon request.

Signature: _____ Date: _____

Relationship to patient (if personal representative): _____