NORTH SHORE
ADVANCED EYE CARE

Welcome to North Shore Advanced Eye Care
Patient Registration Form

In order to serve you, we need the following information. Please print.

Today's Date

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	Gender: M F	Age:	Date of Birth:

Patient's Address:	Appt#:	City/Town:	State:	Zip Code:

Home Phone Number:	Daytime Phone:	Cell Phone:	Student: ☐ Part Time ☐ Full Time

Email Address: (for office use only)	We occasionally communicate by text. Please make sure to provide your cell phone number. Texting? ☐ Opt In ☐ Opt Out

Marital Status: ☐ Divorced ☐ Separated ☐ Single ☐ Married Spouse's Name:

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Self Employed as:

Employer:	Occupation:	Preferred Language:

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Island ☐ American Indian or Alaska Native ☐ Hispanic ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

If patient is below 18 years of age:

PARENT / GUARDIAN #1

Parent /Guardian's Last Name:	First Name:	Middle Initial:	Gender:	Age:	Date of Birth:

☐ Check here if patient lives with this patent/guardian:	Relationship to Patient:

Street Address: (leave blank if same as patient)	Appt#:	City/Town:	State:	Zip Code:

Home Telephone Number:	Work Telephone Number:	Cell Phone Number:	Email Address:

PARENT / GUARDIAN #2

Parent /Guardian's Last Name:	First Name:	Middle Initial:	Gender:	Age:	Date of Birth:

☐ Check here if patient lives with this patent/guardian:	Relationship to Patient:

Street Address: (leave blank if same as patient)	Appt#:	City/Town:	State:	Zip Code:

Home Telephone Number:	Work Telephone Number:	Cell Phone Number:	Email Address:

EMERGENCY CONTACT

Name of Person:	Relationship to Patient:

Telephone Number:	Additional Contact Number:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone Number:
		Fax Number:

YOUR DOCTOR'S INFORMATION

Primary Doctor's Name:	Address:	Office Phone Number:

Other Doctor's Name:	Address:	Office Phone Number:

REFERRAL SOURCE

How did you hear about the office? ☐ Patient ☐ Professional Referral ☐ Insurance ☐ Advertising

Who referred you to the office? Patient Name:	Doctor's Name:	Doctor's Town:

PRIMARY INSURANCE INFORMATION			
Insurance Company Name:	Claims Address:	Telephone Number:	
ID Number:	Group Number:		
Policyholder's Name:	Date of Birth:	Social Security Number:	
Employer Name:	Work Telephone Number:		
Employer's Address:	City/Town:	State:	Zip Code:
SECONDARY INSURANCE INFORMATION			
Insurance Company Name:	Claims Address:	Telephone Number:	
ID Number:	Group Number:		
Policyholder's Name:	Date of Birth:	Social Security Number:	
Employer Name:	Work Telephone Number:		
Employer's Address:	City/Town:	State:	Zip Code:

AUTHORIZATION FOR RELEASE OF INFORMATION BY NORTH SHORE ADVANCED EYE CARE

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize North Shore Advanced Eye Care to furnish all records and results to the parties I specify.

PATIENT/GUARDIAN PRINT NAME:_____ **RELATIONSHIP TO PATIENT:** _____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carries or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT/GUARDIAN PRINT NAME: _____ **RELATIONSHIP TO PATIENT:** _____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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ADVANCED EYE CARE

HIPAA Consent Form and Acknowledgement for the Notice of Privacy Practices

Patient Name (print): _____ **Patient Date of Birth:** _____ /_____ / _____

Phone Number: ( ) _____ **Email:** _____

As a result of the Health Insurance Portability Accountability Act (HIPAA), enforced y the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes as stated below.

This consent authorizes North Shore Advanced Eye Care to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my cell phone: ____ Yes____ No

Leave a voice mail recording including my Personal Health Information on my business phone: ____ Yes____ No

Leave a voice mail regarding appointment changes, cancellations or confirmations on my home cell phone or business phone number: ____ Yes____ No

Use of electronic communications systems (i.e. fax, electronic messaging) to transmit prescription, Treatment, disorder related information, lab or other results: ____ Yes____ No

Use of email to transit treatment of disorder related information, which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the internet). ____ Yes____ No

Permit the individual stated below (Personal Representative) to receive prescription an/or test results: ____ Yes____ No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: ____ Yes____ No

Name of Designated Personal Representative (Print): _____

Relationship to Patient (Print):_____

On this date _____, I received and reviewed North Shore Advanced Eye Care's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I understand that my medical information may be maintained in an electronic health record and accessed remotely or transmitted securely over the Internet.

I acknowledge that by giving consent to this Organization, any or all of the doctors within North Shore Advanced Eye Care that are involved in my care may access these records.

*** If there is any Specialty that requires restriction, please document here:** _____

I had an opportunity to raise questions regarding this policy and all my questions have been answered. _____ Yes ____ No

The authorizations made above will remain effective until such time as I notify North Shore Advanced Eye Care in writing, by certified mail, of requested changes.

_____ _____

Patient or Parent/Guardian/Personal Representative Signature Today's Date

_____ _____

Print Full Name Relationship to Patient (Print)

NORTH SHORE
ADVANCED EYE CARE

Date:_____

Patient's Name:_____

Do you currently wear: glasses contacts interested in contacts (please circle one)

Please circle any of the following that apply to your medical history.

High blood pressure	Brain tumor	Asthma
Heart attack	Headache	Shortness of breath
Heart Disease	Head injury	Emphysema/COPD
Stroke	Seizures	Ear/Nose/Throat problems
High Cholesterol	Thyroid Disease	Nervous disorder
Pacemaker	Diabetes	Skin disorder
Arthritis	Bowel problems	Cancer
Rheumatoid disease	Ulcer disease	Prostate disease
Kidney disease	Currently pregnant or nursing	Blood disease
Other		

Please circle any of the following that apply to your eye history

Dry eyes/blephartitis	Corneal Transplant	Cataract
Double vision	Diabetic retinopathy	Eye injury
Lazy eye	Retinal detachment	Macular degeneration
Iritis/Uveitis	Glaucoma	LASIK/PRK/RK

Please **list any eye surgeries or laser treatment** you have had in the past _____
_____
_____

Please **list all medications you are taking:**_____
_____
_____

Do you have any medication allergies/reactions? Yes No
Please list: _____

Social History:

Alcohol Use: None / rarely / Occasional

Tobacco Use: (Cigars, Cigarettes, Chew) Current / former / never
Years used:_____
Year quit: _____

Do any of your immediate family members have any of the following: (Please circle)

Diabetes	Glaucoma	Muscle disorders of the eye
Blindness	Macular degeneration	Retinal detachment