Thurston Ophthalmology

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name __________________________________ MI ______ First Name ___________________________________

Date of Birth ________________________ Social Security Number____

Home
Address____
Street *City* *State* *Zip*

Mailing Address if
different____
Street *City* *State* *Zip*

Home Phone _____________________ Work Phone ______________________ Other/Cell Phone
____

Email____

Spouse's Name _________________________ DOB _______________ Employer__________________________

Primary Care Physician ____

Referring Physician ____

How did you hear about our health center? ____

Employment Information:

Employer Name: ____

Employer Address
____
Street *City* *State* *Zip*

Responsible person: (if different from patient)

Last Name __________________________________ MI ______ First Name __________________________________

Date of Birth ________________________________ Telephone #
____

Address____
Street *City* *State* *Zip*

Relationship to patient____

HIPPA/Emergency Contacts: Name of relative or friend we can discuss your medical needs with if necessary:
Name: ____ **Relationship:** ____________________________
Ph#______________________
Name: ____ **Relationship:** __________________________
Ph# ______________________

General Medical History Questionnaire

Do you have or have ever had diseases or conditions of: (Please circle YES or No)

Aids/HIV	Yes	No	High Cholesterol	Yes	No
Ankle Swelling	Yes	No	Kidney Dialysis	Yes	No
Arthritis	Yes	No	Kidney Stones	Yes	No
Anemia/Sickle Cell	Yes	No	Multiple Sclerosis	Yes	No
Autoimmune Disease	Yes	No	Osteoporosis	Yes	No
Cancer	Yes	No	Pace Maker/Defib	Yes	No
Chest Pain	Yes	No	Premature Infant	Yes	No
Chronic Cough	Yes	No	Psychiatric Disorder	Yes	No
Diabetes	Yes	No	Pregnant/Nursing	Yes	No
Epilepsy/Seizures	Yes	No	Rheumatoid Arthritis	Yes	No
Facial Trauma	Yes	No	Sjogren's Syndrome	Yes	No
Head Trauma	Yes	No	Sleep Apnea	Yes	No
Headache/Migraines	Yes	No	Stroke/TIA	Yes	No
Hepatitis/Liver Disease	Yes	No	Thyroid Disease	Yes	No
Heart Attack/Disease	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Weakness/Numbness	Yes	No

Please explain any "yes" answers:

____

____

Any family history of above conditions?

____

____

Please list surgical history:

____

Please list allergies:

____

Do you drive? _______________

Do you drink alcohol? ___________ **If "yes", drinks per day** ________________

Do you smoke? Have ever smoked? _________ **If "yes", packs per day** __________________

Do you use illicit drugs? _______________ **If "yes", how much per day** _______________

Do you have an Advance Directive for Healthcare? _____________________________________

Do you have or have ever had diseases of conditions of: (Please circle YES or No)

Cataracts	Yes	No	Blurred Vision	Yes	No
Retinal Detachment	Yes	No	Dry Eyes	Yes	No
Iritis/Inflammation	Yes	No	Watery Eyes	Yes	No
Corneal Disease	Yes	No	Eye Pain	Yes	No
Glaucoma	Yes	No	Flashes or Floaters	Yes	No
Eye Injury	Yes	No	Halos	Yes	No
Macular Degeneration	Yes	No	Seasonal Allergies	Yes	No
Retinitis Pigmentosa	Yes	No	Problems with glare	Yes	No
Diabetic Retinopathy	Yes	No	Previous eye surgery	Yes	No

Please explain any "yes" answers:

____

____

Any family history of above conditions?

____

____

Do you wear glasses or contact lenses?

____

If glasses, how old are they? ____

If contacts, what type? Soft Daily wear Extended wear Rigid gas permeable

Date of last eye exam? _________________

Would you like any information regarding any of the following services and procedures?

_______ **Eyelid surgery**

_______ **Botox treatment for facial lines**

_______ **Lasik**

Authorization and Consent

I request care from Thurston Ophthalmology for treatment of my medical condition. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Thurston Ophthalmology receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Thurston Ophthalmology and/or its Affiliates
2. I agree to let my doctor(s) and/or the Thurston Ophthalmology submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program, including a refraction fee. The refraction fee is a separate fee from the eye examination fee. Our office fee for a refraction is **$35.00** and this fee is collected at the time of service in addition to any co-payment your plan may require.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

4. I hereby acknowledge that a copy of Thurston Ophthalmology's Notice of Privacy Practices/HIPPA has been made available to me to review and that a copy is available at my request.

Signature of the patient (or person authorized to sign for patient) ____________________________________

Relationship to Patient ___________________________________ Date ________________________________

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Authorized Staff Signature **Date**