South Grove Eye Care
Patient Registration, Privacy and Consent
Some questions are being asked to comply with new Health Care laws

Patient Name ______________________ Date of Birth ______________ Gender ______

Occupation ____________SSN#__________ ***(not for minor dependents; may be needed for insurance)***

Parent or Guardian if patient is a minor: Name ______________Relationship to patient _______

Contact Information: Please check the boxes below to verify if you want to participate in our online system to request appointments, receive reminders, confirm appointments, etc. By signing below you agree to allow this system to use the information in providing your services.

Address ____________________________City/ST/ZipCode ____________________

Cell phone ________________ Texting ❑**Opt In** ❑**Opt Out** Home phone __________________

Email Address ____

1. Preferred Language: ☐ **English** ☐ **Spanish**

2. Race: ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **African American** ☐ **Native** ☐ **Hawaiian/Pacific Islander** ☐ **White** ☐ **Other** ☐ **Decline to Answer/Specify**

3. Ethnicity: ☐ **Hispanic or Latino** ☐ **Native Hawaiian/Pacific Islander** ☐ **Not Hispanic or Latino**

How did you hear of our office? ***Please check one***

{ } Insurance { } Yellow Pages { } Sign { } Newspaper { } Referral __________________________ { } Other

If you are Age 18 and above
I specifically authorize SGEC to disclose my private health information according the guidelines in its NPP to the following person(s):

Name ________________________________Relationship ______________

Name ________________________________Relationship ______________

Name ________________________________Relationship ______________

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I am aware of South Grove Eye Care PCs (SGEC) Notice of Privacy Policy and Practices (NPP). I'm also aware a copy will be made available to me upon request. I authorize & consent SGEC to use/disclose private health information about me according to the guidelines in its NPP. This includes information required to file my insurance claim, carry out treatment, etc.

I authorize my insurance company to pay SGEC directly on my behalf & for said insurance company to provide any information required to resubmit denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

I understand I am responsible for any charges not covered by insurance.

______________________________ ______________
Signature of Patient / Parent / or Guardian Date signed

South Grove Eye Care
Patient History

Some questions are being asked to comply with new Health Care laws

Patient Name ____Date of Birth____________________

Primary Care Doctor ____Last **Medical** Exam____________________

Are you a diabetic ____Yes ____ No If yes, What is the name of the Doctor who monitors your diabetes ____________________

- ☐ Yes, I agree to have my eyes dilated today; if you are a diabetic you will have your eyes dilated today.
- ☐ No, instead I choose to have a retinal image taken for a small fee of $25 instead of dilation (see below):

For our patients who decline to have their eyes dilated, which we don't charge for as part of an eye exam, you may request having a retinal image taken for a charge of $25. A retinal image from this camera does not provide a view as good as traditional dilation; however, it is better than not having your eyes dilated at all. I understand the above disclaimer and agree to pay the charge of $25.

For established patients only ☐ No changes to medical history. ☐ Make any changes or additions below then please continue to signature and date at the bottom of the form.

Medications (please list over-the counter also) ____
____

Do you have allergies to medications? Yes No
If "yes" please list ____

Do you wear glasses? Yes No
Do you wear contact lenses? Yes No
If "yes" to contact lenses, what type of lenses do you wear? ____________________
Do you sleep in your lenses? Yes No
How often do you discard your lenses? ____________________
What type of solution do you use? ____________________

For Office Use Only

Age__________ Est / New

BP ____________

NCT ____________

FDT ____________

Color ____________

Stereo ____________

PD ____________

OD Rx ____________

OS Rx ____________

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS? PLEASE EXPLAIN

Condition	Yes	No
Are you pregnant or nursing?	Yes________________	No
Ear/Nose/Throat (sinus problems, hearing loss)	Yes________________	No
Endocrine (diabetes, thyroid)	Yes________________	No
Gastrointestinal (abdominal pain, heartburn)	Yes________________	No
Heart (irregular heartbeat, chest pain)	Yes________________	No
Musculoskeletal (arthritis, muscle aches)	Yes________________	No
Neurological (headaches, paralysis, numbness)	Yes________________	No
Psychiatric (depression, anxiety)	Yes________________	No
Respiratory (asthma, shortness of breath)	Yes________________	No
Skin (eczema, rosacea)	Yes________________	No
Urinary (pain w/urination, blood in urine)	Yes________________	No

Family History--Have you or any member of your family (parent, grandparent, sibling) had any of the following conditions?

Condition		Condition	
Blindness	Self or Maternal/Paternal __________	Cancer	Self or Maternal/Paternal __________
Cataract	Self or Maternal/Paternal __________	Diabetes	Self or Maternal/Paternal __________
Glaucoma	Self or Maternal/Paternal __________	Heart Disease	Self or Maternal/Paternal __________
Lazy Eye	Self or Maternal/Paternal __________	High Blood Pressure	Self or Maternal/Paternal __________
Macular Degeneration	Self or Maternal/Paternal __________	Liver Disease	Self or Maternal/Paternal __________
Retinal Detachment	Self or Maternal/Paternal __________	Migraines	Self or Maternal/Paternal __________
Anemia	Self or Maternal/Paternal __________	Seizures/Epilepsy	Self or Maternal/Paternal __________
Arthritis	Self or Maternal/Paternal __________	Stroke	Self or Maternal/Paternal __________
Asthma	Self or Maternal/Paternal __________	Thyroid Disease	Self or Maternal/Paternal __________

Other conditions – please list ____

Surgeries – Please list surgeries, including eye Surgeries____

Social History--

Do you smoke? Yes If yes, how much? ____________________ No
Do you drink alcohol? Yes If yes, how much? ____________________ No
Are you using or have you used recreational drugs? Yes No

Height __________ Weight__________ ☐ Decline to Answer

Signature of Patient/Parent/Guardian ________________________________Date ____________