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 This authorization remains in effect until withdrawn by me.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

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Patient Name _____Date of Birth _____

Primary Care Doctor _____Last **Medical** exam_____

Are you a diabetic? ____Yes ____ No If yes, who is the doctor who monitors your diabetes _____

For established patients only (Please also sign and date at the bottom): □ No changes to medical history □ See changes below

Medications (please list over-the counter also) _____

_____

Do you have allergies to medications? Yes No If yes, please list _____
Females: Currently pregnant/nursing? Yes No
Do you wear glasses? Yes No
Do you wear contact lenses? Yes No If yes, what type? _____
Do you sleep in your lenses? Yes No
How often do you discard your lenses? _____What type of solution do you use? _____
How many hours a day do you wear your lenses? _____How old is your current pair of lenses? _____

Ocular History: Have you or any family member (parent, grandparent, sibling) had any of the following conditions? Please circle

Blindness…….Self Maternal Paternal
Cataract……Self Maternal Paternal
Glaucoma……Self Maternal Paternal
Lazy Eye…….Self Maternal Paternal
Macular Degeneration……Self Maternal Paternal
Retinal Detachment…….. Self Maternal Paternal

Other History: Have you or any family member (parent, grandparent, sibling) had any of the following conditions? Please circle

Anemia…Self Maternal Paternal
Arthritis…Self Maternal Paternal
Asthma…Self Maternal Paternal
Cancer….Self Maternal Paternal
Diabetes……Self Maternal Paternal
Heart Disease…Self Maternal Paternal
HTN……Self Maternal Paternal
Liver Disease…Self Maternal Paternal
Migraine……..Self Maternal Paternal
Seizures/Epilepsy..Self Maternal Paternal
Stroke……. Self Maternal Paternal
Thyroid……Self Maternal Paternal

Other: _____

Surgeries (including eye surgeries): _____

Social History:
Do you smoke? Yes No If yes, how much_____
Do you drink alcohol? Yes No If yes, how much_____
Are you using or have you used recreational drugs? Yes No Decline to Answer
Height _____ Weight_____ □ Decline to Answer

Signature of Patient/Parent/Guardian _____**Date** _____

Office Use Only

Age_____ Est / New
BP_____
Diaton_____
FDT_____
Color_____
Stereo_____
PD_____
RT Rx_____
LT Rx_____
RT AutoRef_____
LT AutoRef_____
iWellness_____