EXAM CHECKLIST AND REGISTRATION

Our objective is to provide you the best vision care. To do this, it is necessary that we know everything we can about your eyes, your seeing needs, and your present health condition. If you declare assistance in completing this form, our staff will be happy to help you.

Patient:
Name: ____ Birth Date: _________________
Guardian: __________________________________ Relation: ___________________________
(If under the age of 18, please provide the name of your legal guardian)
Occupation: _________________________________ Employer: _________________________
(If student, indicate school, grade, and teacher's name for grades 1-6)
Email: ____

Children in family: (Include pets if you would like)
Name Age
____
____
____
____

How did you hear about us?
_____ Friend
_____ Family Member
_____ Already a Patient
_____ Doctor: ______________
_____ Other: _______________

Would you prefer to be called by your first name?: ______ Yes ______ No
What are your hobbies? ____
____

Please check any of the following that apply:
____ Desire CRT
____ Desire Vision Correction
____ Desire Contact Lenses

Most recent visual or eye exam:
Date: _______________________
Doctor: _____________________
Medical Dr. __________________

Previous visual or eye care:
___ Full time glasses
___ Part time glasses
___ Contact lenses
___ Visual training therapy
___ Eye surgery
___ Orthokeratology/CRT
___ Low vision aid
___ Eye medications: ___________________________________

Please check any of the following that apply to you:
___ Hold reading close
___ Closer or cover one eye
___ Eyes frequently red
___ Lose place when reading
___ School achievement problem
___ Bothered by light
___ Make poor dist. adjustments
___ Double vision
___ Blurred vision
___ Pain or discomfort
___ High or low blood pressure
___ Sinus trouble
___ Diabetes
___ Thyroid problems
___ Cross eyed
___ Eye disease
___ Headaches
___ Past severe headaches
___ General health problems: ____
___ Medications: ____
___ Allergies: ____

Signature: ____ Date: ____________________

DRUG ALLERGIES:

____

____

Do you have **LATEX** sensitivity or allergy? ________________
Describe symptoms if yes ____

Eye drops, including artificial tears:

____

Current medications: (including oral contraceptives, aspirin, over the counter medications and home remedies). Please list medication name and dosage:

____
____
____
____
____

Social History:

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes _____ I would prefer to discuss my social history information with my doctor.

Do you drive?	NO _______ Yes ______
Do you smoke?	NO _______ Yes ______
How many packs per day?	NO _______ Yes ______
Do you use smokeless tobacco products?	NO _______ Yes ______
Do you drink alcohol?	NO _______ Yes ______
Do you use illegal drugs?	NO _______ Yes ______

Have you ever been exposed to or infected with (please circle) Gonorrhea, Hepatitis, HIV, Syphilis, MRSA?

MISC:

Are you pregnant and/or nursing?	NO _______ Yes ______
Do you wear glasses?	NO _______ Yes ______
Do you wear contact lenses?	NO _______ Yes ______

Is there any other information, not covered on this questionnaire that you feel will allow us to better serve your needs?

____
____

Please check any that apply:
My eyes feel:
___ tired ___ sticky ___ foreign body sensation ___ burning ___ watery
___ redness ___ gritty ___ blurred vision ___ like a film is over them

If any of the above, which eye? Right _____ Left ______ Both _____
How long? ________ How often? __________________
During what activities / or when are these symptoms worse? _______________________

Patient Information

Last Name ________________ First Name __________ M.I. ____ Gender _____ Marital Status ____________ D.O.B. ___________ Social Security # ________________

Address

Street ____

____

City _________________ State ______ ZIP Code ____________

Email Address ____
Emergency Contact Name ______________________ Phone Number ____________________
Pharmacy Name ______________________ Phone Number _____________________
Referring Physician: _____________________________
General Physician: ______________________________
Employer Name ____
Occupation ___________________________________

Insurance Information

What is the name of your primary medical insurance? ______________________________________
Policy ID # ______________________________ Primary Policyholder _______________________________
Relationship to Patient ____________________

What is the name of your secondary medical insurance? ______________________________________
Policy ID # ______________________________ Primary Policyholder _______________________________
Relationship to Patient ____________________

Do you have a secondary Vision Plan attached to your general Medical Insurance? _________
(circle)

Davis Vision Spectera EyeMed UHC Vision

Person to be billed (if different than patient)
Name ________________________________
Street Address __________________________________

____

City, State, ZIP __________________ __________ ________
Phone Number _______________________
Relationship _______________________

HIPAA Approved Contacts
Name _________________________________ D.O.B. ______________________
Street Address ___________________________________

____

City, State, ZIP __________________ __________ _________
Phone Number _______________________
Relationship _______________________

Patient or Authorized Person's Signature
I, the undersigned, give my authorization to treat and assign directly to RHK, Inc. all medical benefits, if any, otherwise payable for me for services rendered. I understand that I am financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment of services rendered to me and conducting healthcare operations.

Signature ____ Date _______________________

Medical History Questionnaire

Please fill in all areas or list them as N/A

Name: ____ Today's Date: _____________
Date of Birth: ________________________

Name of Medical Doctor:_____________________________ I do not have one: ______

Name of your Cardiologist: _________ Last visit there: ______ I do not have one: _____

If you were referred by a doctor, please list their name: ___________________________

Past Eye disease or surgeries: ____

Medical Conditions: (please check all that apply)

__ Diabetes
__ High Blood Pressure
__ Heart Disease
__ High Cholesterol
__ Irregular Heart Rhythm
__ Stroke
___ Heart Attack
___ Hepatitis
___ Kidney Failure/Dialysis
___ Arthritis
___ Cancer (location)_________
___ Obstructive Sleep Apnea
___ Thyroid Disease
___ Depression
___ Asthma
___ COPD
___ Immunizations up to date
___ Other ________________

Height ______ Weight _____ **Do you have?** Pacemaker: Yes No Defibrillator: Yes No

Head or Eye Injuries? Please list: ____

Surgeries: (Please list all surgeries, anywhere on the body)

____
____
____
____

Did you have any problems with anesthesia? _________ What problem? ___________________________

Family History:

Please circle any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions.

Disease/Condition	Relationship to you				
	Mother	Father	Sibling	Grandparent	Family
Glaucoma	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Problems with Anesthesia	_____	_____	_____	_____	_____

RHK, Inc.

Patient Signature Form

Privacy Practices Acknowledgement

I have received the HIPAA Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient ________________________________ Date __________________

Please Read the Following Statements and Sign

I authorize release of medical information. I consent to photography. This authorization shall be binding from the date of signature. A copy of this release will be as legal and binding as the original.

I understand all office visits are to be paid at the time that services are rendered. I also realize that I am responsible for payment before filing with my insurance. For any services rendered, I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made to RHK, Inc. I authorize any holder of medical or other information about me to release to the Health Care Finance Administration Insurance company and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient _____________________ Date ____________________

One Time Medicare Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature of Patient ____________________________ Date ___________________