Patient Registration Form

Date ____/____/_______

Family Vision Care
www.myfamilyvisioncare.com
228 Barks Rd East; Marion, OH; 43302
(740) 389-2306

Patient Information

Name ____ Preferred Name _______________
LAST NAME FIRST NAME MI

Address ____ Soc. Sec. # ________________

City ______________________________ State _______ Zip ______________

Phone ❑ Home____________________ ❑ Cell ___________________ ❑ Work ____________________
Please check box next to best number to call

Email Address ____

Gender: ❑ M ❑ F Birth Date _____/_____/_______ ❑ Single ❑ Married ❑ Widowed ❑ Divorced
MM DD YYYY

Patient Employed by ________________________________ Occupation ___________________________

Hobbies______________________________

New Patients: How were you referred to our office? ____

Vision Insurance Information (Please present all insurance cards at your appointment)

Vision Insurance Company ________________________________ Policy Group # ___________________

Insured's Name ____ ID# ____________________________

Insured's Birth Date ____/____/_______Patient's Relationship to Insured ____________________________

Medical Insurance Information (Please present all insurance cards at your appointment)

Medical Insurance Company _______________________________ Policy Group # ___________________

Insured's Name ____ ID# ____________________________

Insured's Birth Date ____/____/_______Patient's Relationship to Insured ____________________________

In case of emergency, contact _________________________________ Phone_________________________

Phone Contact Policy

Unless I notify Family Vision Care to the contrary, any time I provide Family Vision Care with a contact telephone number, whether a residential, work or cell number, I consent to receive calls or text messages from Family Vision Care at such number(s). Such communications may concern my eye care, billing, insurance or payment matters. Such calls or text messages can include pre-recorded messages, artificial voice messages, automatic telephone dialing or other computer assisted technology, or any other form of electronic communication from Family Vision Care or its affiliates, contractors, clinical providers, attorneys, or agents, including collection agencies.

Financial Policy – Benefit Assignment

Payment is expected at the time of service, unless we participate in your insurance plan. If your insurance company fails to pay for your claim, the charges become your responsibility and you will be issued a statement.

- I authorize the release of any medical information needed to process any insurance claims.
- I authorize payment of any insurance benefits directly to Family Vision Care.
- I accept that I am ultimately responsible for all fees for all services rendered. If my account is not paid in full within 60 days, I will be responsible for any collection fees, attorney fees, and court costs.

Acknowledgement of Privacy Practices

I acknowledge that I have read the policy of Family Vision Care's notice of privacy practices. I understand a copy will be provided upon my request. I understand I can call Vicki Brake (HIPAA Privacy Officer) at 740-389-2306.

I have read and understand the above policies.

Patient/Guardian Name (Sign) ____ Date: ___________________

Patient/Guardian Name (Print) ____

Patient Medical History Form

Date ____/____/_______

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I.D. #: _______________
(office use only)

Patient Name ____ **Birth Date** ____/____/________
LAST NAME FIRST NAME MI

Name of Primary Care Physician ___________________________________

Preferred Pharmacy: _______________________________ **Pharmacy Phone #:** _______________________

Medications/Vitamins/Supplements:	Dosage:	Frequency:

Reviewed by: (patient's initials)	Date Reviewed:

Please check all that apply below

Medical Conditions:

- ❑ ADHD
- ❑ Anxiety/depression
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Hearing impaired
- ❑ Heart
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney condition
- ❑ Migraines
- ❑ Seizures
- ❑ Skin condition
- ❑ Stroke
- ❑ Weight loss or gain
- ❑ Other: _________________________________

Eye Conditions:

- ❑ Cataracts
- ❑ Eye surgery: ❑ Right Eye ❑ Left Eye
  Explain: ___________________________________
- ❑ Eye allergies
- ❑ Glaucoma
- ❑ Injury
- ❑ Lazy eye
- ❑ Macular degeneration
- ❑ Other: _______________________________________

Allergies:

- ❑ None
- ❑ Environmental
- ❑ Nuts/Other food allergies: ______________________
- ❑ Seasonal
- ❑ Drug allergies: specify: ________________________
- ❑ Other: ______________________________________

Appointment of Representative

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APPOINTMENT OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

To appoint an Individual as your personal representative, complete this form.

Patient Name ____

Date of Birth ____________________________

I hereby authorize Family Vision Care to release the following protected health information to the following Individual, who I designate as my personal representative:

Name	Relationship	Personal Health Information That May Be Disclosed
_______________________________	❑ Spouse ❑ Other Relative ❑ Friend ❑ Other	❑ All personal health Information OR ❑ Other (specify): _______________________________ _______________________________
If you wish to designate more than one Individual, please use an additional form.		

I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original appointment. I hereby give permission to Family Vision Care, through its medical providers and personnel, to release to my designee(s) any personal health information as specified above. I release Family Vision Care's medical providers and personnel from any claim of confidentiality in connections with the release of this information. **My designation is valid until I cancel it in writing.**

____ Date: ______________________
Personal Representative's Printed Name

Personal Representative's Address: ____

____

____ Date:______________________
Patient's Signature

____
Patient's Printed Name