HEALTH HISTORY

Patient Information

Patient Name _____ D.O.B. _____/_____/_____

Emergency Contact Name _____ Relation _____

Emergency Contact Phone _____ Eye Doctor _____

Family Doctor _____ Family Doctor Phone _____

Social History

Does your vision limit any activities of daily living? (please check)

☐ driving ☐ reading ☐ sports ☐ work ☐ other _____

Do you drink alcohol? No / Yes How often? _____

Do you smoke? No / Yes How much? _____ For how many years? _____

Family History

Is there any family history of the following? (please circle) If yes, list family member:

Blindness	No / Yes _____	Cataract	No / Yes _____
Glaucoma	No / Yes _____	Diabetes	No / Yes _____
Macular Degeneration	No / Yes _____		

Past Visual & Medical History

Have you ever had any eye injuries or surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Have you ever had any other surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Do you have any history of cancer? ☐ No ☐ Yes If yes, please explain:

_____

Please list any medications and why you are taking them:

_____ _____

_____ _____

_____ _____

_____ _____

Please fill out other side

NAME ______________________________

Have you ever taken medications for enlarged prostate (Flomax, Tamsulosin, doxazosin)? ☐ No ☐ Yes

Are you allergic to any latex products? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes, please list: ______________________

Do you use oxygen? ☐ No ☐ Yes, only at night ☐ Yes, all the time

Are you currently enrolled in hospice? ☐ No ☐ Yes

Are you currently enrolled in an HMO health plan? ☐ No ☐ Yes

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic
- ☐ drug allergy
- ☐ environmental allergy
- ☐ other allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other ____________
- ☐ **NONE**

Lungs/Breathing
- ☐ cigarette smoker
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ sleep apnea **CPAP:** Y N
- ☐ other ____________
- ☐ **NONE**

Endocrine
- ☐ non-insulin diabetic
- ☐ insulin diabetic
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ pregnant/breastfeeding
- ☐ other ____________
- ☐ **NONE**

Eyes
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ inflammatory disorders
- ☐ previous surgery
- ☐ other ____________
- ☐ **NONE**

Gastrointestinal
- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive problems
- ☐ other ____________
- ☐ **NONE**

Cardiovascular
- ☐ heart disease
- ☐ defibrillator
- ☐ high blood pressure
- ☐ stroke
- ☐ poor circulation
- ☐ high cholesterol
- ☐ other ____________
- ☐ **NONE**

Musculoskeletal
- ☐ arthritis
- ☐ muscular dystrophy
- ☐ fibromyalgia
- ☐ ankylosing spondylitis
- ☐ other ____________
- ☐ **NONE**

Genitourinary
- ☐ STD
- ☐ urinary problems
- ☐ prostate problems
- ☐ other ____________
- ☐ **NONE**

Neurological
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ other ____________
- ☐ **NONE**

Skin
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other ____________
- ☐ **NONE**

Constitutional
- ☐ developmental disability
- ☐ sudden weight loss
- ☐ fatigue
- ☐ trauma
- ☐ other ____________
- ☐ **NONE**

Psychiatric
- ☐ depression / anxiety
- ☐ panic disorder
- ☐ schizophrenia
- ☐ dementia/alzheimer's
- ☐ other ____________
- ☐ **NONE**

Blood/ Lymphatic
- ☐ leukemia
- ☐ anemia
- ☐ large volume blood loss
- ☐ use blood thinner (ie Coumadin)
- ☐ other ____________
- ☐ **NONE**

Ear, Nose, Throat
- ☐ upper respiratory tract infection
- ☐ other ____________
- ☐ **NONE**

For Office Use Only

Medical History Updates: Date: ____________ Tech Initials: ____________ Doctor Initials: ____________

Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:

MEDICATION LIST

PLEASE COMPLETE THIS FORM WITH YOUR MEDICATIONS AND BRING TO YOUR APPOINTMENT.

MEDICATION	HOW MANY TIMES PER DAY	DOSAGE (mg)

DATE *(FECHA)* _____

ACCT. # _____

☐ NEW
☐ UPDATE

PLEASE PRINT CLEARLY
FAVOR DE IMPRIMIR

PATIENT *(PACIENTE)*

PATIENT LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	PREVIOUS NAME (MAIDEN) *(APELLIDO DE SOLTERA)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMIENTO)*	
SEX *(SEXO)* ☐M ☐F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SS # (LAST 4 DIGITS) *# SS (LOS ÚLTIMOS CUATRO DÍGITOS)* ___ ___ ___ ___	
MARITAL STATUS *(ESTADO CIVIL)* ☐S ☐M ☐W ☐D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZÓA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	

email: _____

RESPONSIBLE PARTY (MAIN INS. CARDHOLDER) (*NOMBRE DE LA PERSONA ASEGURADA)*

LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMIENTO)*	
SEX *(SEXO)* ☐M ☐F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SS # (LAST 4 DIGITS) *# SS (LOS ÚLTIMOS CUATRO DÍGITOS)* ___ ___ ___ ___	
MARITAL STATUS *(ESTADO CIVIL)* ☐S ☐M ☐W ☐D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZÓA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	

EMERGENCY CONTACT

RELATIVE / FRIEND (Not living at same address)
(REFERENCIA PERSONAL (Que no viva en su mismo domicilio))

LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)* ZIP *(CÓDIGO POSTAL)*		HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*	ADDRESS *(DOMICILIO)*		EMPLOYER TELEPHONE *(TELEFONO DEL EMPLEADOR)*

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

MEDICARE

Name of Beneficiary_____ Claim #_____
I request that payment of authorized benefits be made either to me or on my behalf to _____ for any services furnished me by my physician. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.
A copy of this signature is as valid as the original.

Signature _____

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is as valid as the original.

Signature _____

MEDICARE

Nombre del beneficiario _____Reclamación No. _____
Solicito que el pago do los beneficios autoizados se me haga directamente a mí o, que en mí nombre, se le entregue a: por cualquier servicio que me haya prestado mi médico. Autorizo a quienes tengan información médica relacionada conmigo a que le revelen a la adminstración encargada de financiar el cuidado de la salud y a sus agentes, cualquier información que sea necesaria para determinar estos beneficios o los que deban pagarse por servicios relacionados. Autorizo a Medicare a que le proporcione al médico, cuyo nombre aparece arriba, cualquier información relacionada con mis reclamaciones de Medicare según se estipula en el Título XVIII de la ley del Seguro Social.
Una copia de esta firma es tan válida como la original.

Firma _____

SEGURO COMERCIAL

Por este medico autorizo a que se revele la información necesaria para presentar una reclamación con mi compañía de seguros y para asignarle, al médico o al grupo indicado en dicha reclamación, los beneficios que de otra manera me serían pagados a mí. Entiendo que soy responsable de saldar cualquier importe que no sea cubierto por mi compañia de seguros.
Una copia de esta firma es tan válida como la original.

Firma _____

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

NAME OF HEALTH CARE PROVIDER

NAME OF MEDICAL OFFICE/HOSPITAL

STREET ADDRESS

CITY, STATE AND ZIP CODE

( ) PHONE ( ) FAX

Please **SEND** Medical Information **TO**:

NAME OF PERSON OR ENTITY TO RECEIVE INFORMATION

TITLE (PHYSICIAN, THERAPIST, ATTORNEY)

STREET ADDRESS

CITY, STATE AND ZIP CODE

( ) PHONE ( ) FAX

I hereby authorize _____ **to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

Release and/or disclose records and information regarding:

NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE ( ) TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect _____ *(enter date)* or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

Check the box and initial which type of information is to be released and/or disclosed:

- ❑ **General Medical Information** *(from _____ to _____)*
- ❑ **Information Regarding Specific Injury or Treatment** *(from _____ to _____)*
- ❑ **X-Ray (check one or both):** ❑ **Films** ❑ **Reports**
- ❑ **Laboratory Results**
- ❑ **Mental Health** *(from _____ to _____)* SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE
- ❑ **Alcohol/Drug** *(from _____ to _____)* SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE
- ❑ **HIV Test Results** *(from _____ to _____)* SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE
- ❑ **Other (specify):** _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

DATE SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE INDICATE RELATIONSHIP (IF SIGNED BY OTHER THAN PATIENT)

CMGH-606 **ORIGINAL** – DISCLOSING PARTY **CANARY** – CHART **PINK** – PATIENT

Haven Eye Institute, Inc.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name and address of Patient: _____

_____

_____

HAVEN EYE INSTITUTE, INC.

GENERAL CONSENT

I hereby consent and request diagnostic procedures including x-rays, blood tests, injections, including medical treatment deemed advisable by the professional staff of Chaparral Medical Group, Inc. I acknowledge that I have read this consent form and understand its contents. I have have an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

WITNESS _____ PATIENT'S SIGNATURE _____

DATE _____ PARENT'S OR LEGAL GUARDIAN'S SIGNATURE _____

MEMBER ELIGIBILITY WAIVER

Verification of your coverage for health plan benefits cannot be made at this time. Services will be provided to you at this visit: however, in the event your coverage is not effective, you will be held responsible for payment of services.

Patient Name: _____ SS # (last 4 digits): _____ _____ _____ _____

Subscriber Name: _____ SS # (last 4 digits): _____ _____ _____ _____

Address: _____ City: _____ St: _____ Zip Code: _____

Insured Phone No. (Day) _____ (Evening) _____

Medicare No: _____ Date of Birth: _____

Subscriber's Employer: _____ Phone No: _____

Patient's Signature: _____

PHOTO CONSENT

I, the undersigned, do hereby agree to the following: I am allowing a Chaparral Medical Group staff member to take photos of my treatment and/or treated areas for the purpose of monitoring my progress.

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

HAVEN EYE INSTITUTE, INC.

Patient Authorization

"Health Insurance Portability and Accountability Act" (HIPPA)

Please print the telepone numbers where you want to receive calls or information about your appointments, labs or other health care issues that would come directly from our physicians or staff members:

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

Can confidential messages (ex: appointments, labs or referrals) be left on your home answering machine or cell phone voicemail:

Yes: _____ No: _____

Please list the family member or other persons, whom we may inform about your general medical condition and/or diagnosis:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The information on this authorization is good for the period of one year from the date it is signed and agreed by the patient.

Patient Name:Name: _____ Date: _____

Patient/Guardian Signature: _____

• ADMINISTRATIVE RESOURCES
• HAVEN EYE INSTITUTE, INC.

PATIENT FINANCIAL RESPONSIBILITY POLICY

We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.

Non-Covered Services: Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

Correct Insurance Information: You are responsible for providing us with the correct and updated information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or change in insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

Payment is required at the Time of Service: You are responsible for paying deductibles, copayments, coinsurance and other out of pocket expenses not covered by your insurance plan at the time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks, we also accept most major credit/debit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

Any Payments received may be applied to any unpaid bill(s) for which the patient or legal guardian/conservator is liable. After ninety (90) days, any and all balances assigned as patient responsibility may be subject to collection efforts.

Legal Guardian/Conservator: The patient's legal guardian (if a minor) or conservator (if an incapacitated adult) is responsible for the payment of co-pays, co-insurance, deductibles, and all procedures or treatments not covered by their insurance plan.

Missed Appointments: Missed appointments without 24-Hours Advance Notice will result in a $50.00 charge per occurrence and the patient may be subject to discharge from the practice. Please give us the courtesy of 24 hr. advance notice to reschedule your appointment.

Administrative Charges: Patients may incur, and are responsible for the payment of additional charges at the discretion of Administrative Resources / Haven Eye Institute, Inc. The charges may include but are not limited to (subject to change at any time):

- Charge for returned checks is $25.00
- Charge for copying and distribution of patient medical records is $25.00
- Charge for forms completion, including but not limited to disability and FMLA forms is $35.00
- Charge for extensive phone consultations and/or after hour's phone calls requiring diagnosis, treatment or prescriptions. Charged at the discretion of the physician.

Patient/Legal Guardian/Conservator Authorization (By my signature below):

I hereby authorize Administrative Resources / Haven Eye Institute, Inc., to release ALL medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

I hereby authorize assignment of financial benefits directly to Administrative Resources / Haven Eye Institute, Inc., and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by the insurance plan are patient/legal guardian/conservator responsibility. I also understand that account balances not paid within ninety (90) days from the first Statement Date may be sent to a Collection Agency.

I authorize Administrative Resources / Haven Eye Institute, Inc., and Collection Agency personnel to communicate with patient/legal guardian/conservator by mail, telephone (including cell phone) and/or email according to the contact information I have provided in the Patient Registration Information.

I have read, understand, and agree with the policies and provisions outlined in this Patient Financial Responsibility Policy.

Patient

_____
Printed Name of Patient

_____
Signature

_____
Date

Date of Birth _____

Social Security Number _____ – _____ – _____

Address _____

City/State/Zip _____

Cell Phone Number _____

Home/Secondary Phone Number _____

Legal Guardian/Conservator (if Applicable)

_____
Printed Name of Guardian/Conservator

_____
Signature

_____
Date

Date of Birth _____

Social Security Number _____ – _____ – _____

Address _____

City/State/Zip _____

Cell Phone Number _____

Home/Secondary Phone Number _____

Waiver of Authorization: I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of all charges and/or to submit claims only to the insurance plan at my discretion.

_____
Signature of Patient/Legal Guardian/Conservator

_____
Date

FILE COPY