TRULY EYE CARE

PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Patient Name *(Last, First, Middle):*					
Parent/Guardian Name *(if minor):*					
Date of Birth:	/ /	Social Security #	*XXX - XX -*		
Address:					
City:		State:		Zip Code:	
Phone:	( )	Email:			
Occupation:		Employer or School:			
How did you hear about us?:					

INSURANCE INFORMATION			
Policy Holder's Name:			
Policy Holder's Employer:			
Policy Holder's DOB:	/ /	SSN:	*XXX - XX -*
Relationship to Patient:			

MEDICAL INFORMATION			
Primary Care Physician:			
PCP Phone:	( )	Fax:	( )
Preferred Pharmacy:		Pharmacy Phone:	( )
Pharmacy Address:			

RELEASE OF INFORMATION			
I hereby give Truly Eye Care permission to receive health records and information about the care of the named patient.			
Signature:		Date:	/ /

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MEDICAL HISTORY			
Do you use tobacco products?	YES / NO	If yes, how often?	
Do you drink alcoholic beverages?	YES / NO	If yes, how often?	

Do you currently have any of these problems? Please check the category box, and which one.

- ☐ Diabetes **[Current A1C: _____]**
- ☐ Cardiovascular: **High Blood Pressure** Heart Surgery Vascular Disease
- ☐ Ear/Nose/Throat: Allergies Sinus Couch Dry Mouth/Throat
- ☐ Respiratory: Asthma Bronchitis Emphysema COPD
- ☐ Skin: Growths Rashes Acne
- ☐ Neurological: Headaches Migraines Seizures Double Vision
- ☐ Endocrine: Thyroid
- ☐ Blood/Lymph: Anemia High Cholesterol Bleeding Problems
- ☐ Gastrointestinal: Chrons/Colitis Ulcer
- ☐ Allergic/Immunologic: Seasonal Allergies Rheumatoid Arthritis Lupus HIV
- ☐ **PLEASE CHECK THIS IF NONE OF THE ABOVE APPLY**

Please list all Current Medications, Dosage & Duration. ***(IF NONE PLEASE WRITE NONE)***

Please list any Allergies or Sensitivities to Medications or Treatments. ***(IF NONE PLEASE WRITE NONE)***

OCULAR HISTORY		
Do you or your family members have any of these problems? If so, please circle one and include any details in the space provided (ie. medication, specialist you see, etc)		
Condition	Medication(s)	Specialist
Dry Eye		
Glaucoma		
Macular Degeneration		
Keratoconus		
Retinal Detachment		
Double Vision or Lazy Eye		
Eye Surgery		

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Patient Acknowledgements

Insurance Coverage Disclosure
I understand that positive verification of my insurance coverage may not always be confirmed at the time of service. If my coverage is not effective, I am responsible for payment for services rendered. I acknowledge that any potential out-of-pocket costs will be disclosed to me prior to receiving services. By signing below, I agree to and understand my financial responsibilities.

Re-Style Policy
I hereby acknowledge that I have read, understood, and will adhere to Truly Eye Care's re-style policy. I am aware that I can request a copy of this policy at any time for my reference. All sales of prescription eyeglasses and contact lenses are final.

Special Circumstance Release Forms
I understand that under specific circumstances during my visit or treatment at Truly Eye Care, I may be required to sign additional release forms. These may include, but are not limited to, the Elimination of Multifocal Lenses form, Polycarbonate Release, and Frame Release, Medical Records Release, or Forms associated with in office treatments. A Truly Eye Care team member will provide these forms when necessary.

Contact Lens Agreement
I hereby acknowledge that I have read, understood, and will adhere to Truly Eye Care's contact lens agreement policy. I am aware that I can request a copy of this policy at any time for my reference.

HIPAA Privacy Rights Acknowledgement
The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of data (“The transaction rules”), the keeping and use of patient records (“privacy rules”) and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

Release of Medical Records
I voluntarily consent to and authorize my health care provider to disclose my health information to Truly Eye Care, 4750 The Grove Drive Suite 164 Windermere, FL 34786 (407) 801-2477 at my request.

Patient Signature: _____ Date: _____

Relationship to Patient (if applicable):_____