HELIX EYE CARE

REGISTRATION (PLEASE PRINT)

Date_____ Home Phone_____ Cell_____

Email Address _____

PATIENT INFORMATION

Name_____ Soc Sec#_____
(Last) (First) (Initial)

Address_____

City_____ State_____ Zip_____

Sex □ M □ F Age_____ Birthday_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Race - □ Asian □ White □ Black/African American □ American Indian □ Refuse to Answer

Ethnicity - □ Hispanic/Latino □ Non Hispanic/Latino □ Refuse to Answer

Employer_____ Occupation_____

Address_____Phone_____

Primary Care Physician: _____Phone:_____

Whom may we thank for referring you?_____

In case of emergency notify?_____ Phone_____

Your Pharmacy (Name & Phone Number):_____

PRIMARY INSURANCE

Person Responsible for Account_____
(Last) (First) (initial)

Relation to Patient_____ Birthday_____ Soc Sec#_____

Address_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Phone_____

Insurance Carrier_____

ID#_____ Group#_____ Plan#_____

Names of other dependents covered_____

HELIX EYE CARE

REGISTRATION CON'T (PLEASE PRINT)

ADDITIONAL INSURANCE

Is Patient Covered By Additional Insurance? □ YES □ NO

Subscriber Name_____Relation to Patient_____ Birthdate_____

Address_____

City_____ State_____ Zip_____

Subscriber Employed By_____ Phone_____

Insurance Carrier_____ Soc Sec#_____

ID#_____ Group#_____ Plan#_____

Names of other dependents covered_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Insurance Company(ies)
and assign directly to Dr._Wang/Dwarakanathan/Diab/Chiranand/Ittiara__all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand I will be responsible for all fees incurred including collection and attorney fees and any/all court costs on balances over 90 days. I further agree upon default, to pay interest accruing at a rate of 1.5% (18% annum) on any unpaid balances. I hereby authorize the doctor to release all information necessary to secure the benefits. I authorize the use of this signature on all insurance submissions.

NO-SHOW FEE

Failure to cancel at least 24 hours before your scheduled appointment will result in a $25.00 no-show fee. This fee will not be billed to your insurance company and must be paid before your next appointment.

_____ _____ _____

Responsible Party Signature | Relationship | Date

HELIX EYE CARE

DATE: _____

PATIENT NAME: _____

ALLERGIES: _____

MEDICATIONS (NAME, DOSAGE, AND FREQUENCY - FOR EYE MEDS PLEASE SPECIFY WHICH EYE):

_____

_____

_____

_____

_____

_____

_____

_____

_____

SMOKE: NO _____ YES _____ FORMER SMOKER? NO _____ YES _____

DRINK: NO _____ YES _____ HOW OFTEN? _____

DRUGS: NO _____ YES _____ DRUGS USED? _____

HOW MUCH? _____ HOW LONG? _____

FAMILY HISTORY (EYE OR OTHER DISEASES): _____

OCULAR HISTORY: _____

PAST OCULAR SURGERIES: _____

PAST MEDICAL SURGERIES: _____

_____

MEDICAL HISTORY:

	Yes	No		Yes	No
Diabetes			Cancer		
High Blood Pressure			Hepatitis		
High Cholesterol			AIDS/HIV		
Heart Disease			Multiple Sclerosis		
Thyroid Issues			Pacemaker		
Kidney Dialysis			Defibrilator		

Other: _____

HELIX EYE CARE

DATE: _____

PATIENT NAME: _____ PATIENT WT: _____ PATIENT HEIGHT: _____

EYES

Previous Surgery	□ YES	□ NO
Contact Lens	□ YES	□ NO
Pain	□ YES	□ NO
Double Vision	□ YES	□ NO
Glaucoma	□ YES	□ NO
Cataracts	□ YES	□ NO
Macular Degeneration	□ YES	□ NO
Dry Eyes	□ YES	□ NO
Flashes	□ YES	□ NO
Floaters	□ YES	□ NO

EAR/NOSE/THROAT

Hard of Hearing	□ YES	□ NO
Ringing in Ears	□ YES	□ NO
Vertigo	□ YES	□ NO

CARDIOVASCULAR

Chest Pain	□ YES	□ NO
Dizziness	□ YES	□ NO
Fainting Spells	□ YES	□ NO
Shortness of Breath	□ YES	□ NO
Irregular Heart Beat	□ YES	□ NO
Difficulty Lying Flat	□ YES	□ NO

CONSTITUTIONAL

Fatigue/Weakness	□ YES	□ NO
Fever	□ YES	□ NO
Weight Gain/Loss	□ YES	□ NO

RESPIRATORY

Cough	□ YES	□ NO
Congestion	□ YES	□ NO
Wheezing	□ YES	□ NO
Asthma	□ YES	□ NO

GASTROINTESTINAL

Heartburn	□ YES	□ NO
Nausea/Vomiting	□ YES	□ NO
Jaundice/Hepatitis	□ YES	□ NO

GENITO-URINARY

Pain/Difficulty	□ YES	□ NO
Blood in Urine	□ YES	□ NO
History of Kidney Stones	□ YES	□ NO
History of STD's	□ YES	□ NO

PSYCHIATRIC

Anxiety/Depression	□ YES	□ NO
Mood Swings	□ YES	□ NO
Difficulty Sleeping	□ YES	□ NO

ENDOCRINE

Increased Thirst	□ YES	□ NO
Increased Hunger	□ YES	□ NO
Increased Urination	□ YES	□ NO
Increased Sweating	□ YES	□ NO
Fingernail Changes	□ YES	□ NO

BLOOD/LYMPHNODES

Easy Bruising	□ YES	□ NO
Gums Bleed Easily	□ YES	□ NO
Prolonged Bleeding	□ YES	□ NO
Heavy Aspirin Use	□ YES	□ NO

MUSCULOSKETAL

Stiffness	□ YES	□ NO
Arthritis	□ YES	□ NO
Joint Pain/Swelling	□ YES	□ NO

SKIN

Rash/Sores	□ YES	□ NO
Lesions	□ YES	□ NO
Hives/Eczema	□ YES	□ NO

NEUROLOGICAL

Seizures	□ YES	□ NO
Weakness/Paralysis	□ YES	□ NO
Numbness	□ YES	□ NO
Tremors	□ YES	□ NO

IMMUNOLOGIC

Hives	□ YES	□ NO
Itching	□ YES	□ NO
Runny Nose	□ YES	□ NO
Sinus Pressure	□ YES	□ NO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Printed Name of Patient — Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____
2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____ Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

_____ I **decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.

HELIX EYE CARE

HIPAA PRIVACY ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have read the HIPAA privacy/Patient Record of Disclosures

Name _____ Birthday _____

Signature _____

Date _____

REFRACTION POLICY

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle glasses and/or contact lenses. This is the test we perform with you looking at an eye chart through multiple sets of lenses until we find the glasses prescription that allows you to see optimally. It can be an essential part of an eye examination, but is NOT a covered service by Medicare or most insurance companies regardless of the reason for the test being performed. If done, our office fee for refraction is $75.00 and is collected at the time of service in addition to the patient's co-pay.

We do not perform refractions requiring prisms

I understand and have read the above policy:

_____ _____

Signature Date