PATIENT REGISTRATION & QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Name (Last, First, M.I.):	☐ **FEMALE** ☐ **MALE**	**DOB:**	**Age:**	**Last 4 Digits SSN:**
Address:		**City/State:**		**Zip Code:**
Home Phone:	**Work Phone:**	**Mobile Phone:**		**Marital Status:**
Email Address:		**How do you prefer to be contacted?**		
Emergency Contact:		**Phone Number:**		**Relationship:**
Employer:		**Occupation:**		**New or Existing Patient?**
Referred By:				
Reason for today's visit:				

MISCELLANEOUS DEMOGRAPHIC INFORMATION

ALL QUESTIONS CONTAINED IN THIS PORTION ARE **OPTIONAL** AND WILL BE KEPT STRICTLY CONFIDENTIAL.

RACE:	☐ HISPANIC ☐ NOT HISPANIC ☐ NO ANSWER				CITIZENSHIP:	
ETHNICITY:	☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	☐ ASIAN	☐ CAUCASIAN	☐ BLACK/AFRICAN AMERICAN	☐ AMERICAN INDIAN/ALASKA NATIVE	☐ UNKNOWN/OTHER:

PAYMENT AND INSURANCE INFORMATION

Please present your insurance card and a picture ID to our receptionist

PRIMARY MEDICAL & VISION INSURANCE:	**SECONDARY MEDICAL & VISION INSURANCE:**
SUBSCRIBER ID#:	**SUBSCRIBER ID#**
GROUP NUMBER:	**GROUP NUMBER:**
POLICY HOLDER:	**POLICY HOLDER:**
IF YOU HAVE VSP (VISION SERVICE PLAN), PLEASE SUPPLY POLICY HOLDER'S NAME, DATE OF BIRTH AND LAST 4 DIGITS OF SSN:	

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. Vision insurance is an exclusive coverage, separate from major medical health insurance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. There will be a service charge of **$25** on all returned checks. Payment from my insurance is to be paid directly to Timothy E. Kale, Optometrist dba ALL EYES. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I authorize Timothy E. Kale Optometrist (dba ALL EYES) or the insurance company to release information required to process my claim.

_____ _____

Please sign here to accept this agreement (Patient/Guarantor) **Date**

OCULAR HISTORY

Do you wear prescription glasses? ☐ Yes ☐ No	**If so, how old is your present pair of lenses?**	
Do you use prescription glasses for the following: ☐ Driving ☐ Computer ☐ Reading		**Do you use over-the-counter reading glasses?**
Are you happy with your current prescription glasses? ☐ Yes ☐ No	**If not, please explain:**	
How many hours (per day) are you using a computer, laptop, smartphone, etc.?		
Are you interested in purchasing a new pair of eyeglasses? ☐ Yes ☐ No		**What type?**
Please list any ocular surgeries (refractive or non-refractive) you've had done:		

CONTACT LENSES

Do you wear contact lenses? ☐ Yes ☐ No	**If so, what brand are you using?**	
What type? ☐ Rigid Gas Permeable ☐ Soft ☐ Toric (for Astigmatism) ☐ Multifocal ☐ Monovision		
How frequently do you replace your contact lenses?		
Are you happy with your current brand of contact lenses? ☐ Yes ☐ No	**If not, please explain:**	

CURRENT OCULAR CONCERNS

Have you been experiencing any of the following?

(If **YES**, please check the box, note right (**R**), left (**L**) or both (**B**) eyes, frequency (**Consistent** or **Inconsistent**) and severity (**Mild, Moderate** or **Severe**).

	Eye	Frequency	Severity		Eye	Frequency	Severity
Blurred Vision				Headaches			
Loss of Vision or Side Vision				Redness			
Double Vision				Burning / Itching			
Flashes and/or Floaters				Tearing			
Sensitivity to Light				Discharge			
Eye Strain				Stye/Chalazion			

SELF AND FAMILY HISTORY

Please note any personal and family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

CONDITION (Ocular)	SELF (Y or N)	FAMILY/RELATION TO YOU	CONDITION (Medical – Family Only)	RELATION TO YOU
Glaucoma			Cancer	
Cataract			Diabetes Type 1	
Macular Degeneration			Diabetes Type 2	
Retinal Detachment			Hypertension / High-Blood Pressure	
Dry Eye			Hyperthyroidism	
Crossed Eye			Heart Disease	

Please list any ocular surgeries (refractive or non-refractive) you've had done:

SOCIAL HISTORY

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Alcohol	Do you drink alcohol? ☐ Yes ☐ No		How many drinks per week?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No		Former Smoker? ☐ Yes ☐ No	
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No		Substance(s) and Frequency:	

MEDICAL HEALTH HISTORY

PRIMARY CARE PHYSICIAN:		**PREFERRED PHARMACY:**	
DATE OF LAST PHYSICAL EXAM:	**HEIGHT:**	**WEIGHT:**	**BLOOD TYPE (IF KNOWN):**
DOMINANT EYE: ☐ **RIGHT** ☐ **LEFT**	**DOMINANT HAND:** ☐ **RIGHT**	☐ **LEFT**	☐ **BOTH**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (use other side of page, if needed).

Name the Drug	Strength	Frequency Taken

Allergies to medications? (Use other side of page, if needed).

Name the Drug	Reaction You Had	Severity (**Mild, Moderate** or **Severe**)

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

CONSTITUTIONAL

- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Weight Gain/Loss

EAR, NOSE and THROAT

- ☐ Hearing Loss
- ☐ Sinusitis/Allergies
- ☐ Dry Mouth
- ☐ Laryngitis

NEUROLOGICAL

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism
- ☐ Dizziness

PSYCHIATIC

- ☐ Depression
- ☐ Attention Deficit Disorder
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Memory Loss

CARDIOVASCULAR

- ☐ **HYPERTENSION/HIGH BLOOD PRESSURE**
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ High Cholesterol
- ☐ Congestive Heart Failure

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis or Chronic Cough
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

GASTROINTESTINAL

- ☐ Crohn's Disease / IBS
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Diarrhea/Constipation

GENITORINARY

- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ Ovarian/Uterine Cancer
- ☐ STDs
- ☐ Pregnant / Nursing
- ☐ Herpes / Chlamydia

MUSCULOSKELETAL

- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Gout
- ☐ General Muscle/Joint Pain

INTEGUMENTARY (Skin)

- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles

ENDOCRINE

- ☐ **TYPE 2 DIABETES**
- ☐ **TYPE 1 DIABETES**
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other

HEMOTOLOGIC/ LYMPHATIC

- ☐ Anemia
- ☐ Large-volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesterolemia
- ☐ Other

ALLERGIC/ IMMUNOLOGIC

- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other

Are you pregnant or nursing? ☐ Yes ☐ No

Notice of Confidentiality Practices

Important: This notice deals with the sharing of information from your medical records. Please read it carefully.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse and children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323C HRS).

Your rights

Under the new law, you have the right to:

- Inspect and request copies of your medical records or to appeal any denial of your request for inspection or copying.
- Request that your health care provider append information to your medical record.
- Receive a notice of your privacy right by your health plan upon enrollment, annually, and when their confidentiality practices are substantially amended.
- Obtain a copy of this document, which describes our office's confidentiality practices.

Uses of information

This office uses your protected health information to provide you with health care services. Under the law, your health information may be shared with physicians and other health care providers who are treating you. Your health information may also be used by such entities such as your health insurance plan for administrative and utilization management purposes. Except for the purposes outlined above, your health information may not be disclosed without your authorization.

Limiting disclosure of your protected health information

You have the right to limit disclosure of your protected health information if you choose not to use any health insurance or other third party payment as payment for services. If this is the case, you may only limit disclosure if you have advised the physician prior to the delivery of services and have paid for the health care services yourself.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Confidentiality Practices.

Name of Patient (please print) _____ Date_____

Signature of patient or legal representative_____ Date_____

If signed by legal representative, please state the relation to the patient

Communication with Family

This authorization gives Timothy E. Kale Optometrist, INC. dba ALL EYES permission to speak to immediate family members regarding my medical information and treatment:

YES NO

(Please circle one)

Additional persons with whom you authorize All Eyes to communicate:

Name _____ Relationship_____

Name _____ Relationship_____