Meadville/Valley
Ophthalmology Associates

PATIENT REGISTRATION FORM

Please present insurance card and photo ID upon registration. Please print the information below:

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: H _____ W_____ CELL _____

EMAIL: _____ MARITAL STATUS: M D W S

SS#: _____ BIRTHDATE: _____ AGE: _____ MALE / FEMALE

FAMILY DOCTOR: _____ PHONE:_____

REFERRING DOCTOR: _____ PHONE: _____

PREFERRED PHARMACY: _____

EMERGENCY CONTACT: _____ PHONE: _____

PARENT/GUARDIAN: _____ SS#: _____ DOB: _____

PAYMENT: IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE OR IF YOU HAVE NOT PRESENTED THE CORRECT INSURANCE CARD, SOCIAL SECURITY NUMBER AND DRIVER'S LICENSE, YOU AGREE TO PAY THE FACILITY'S REGULAR RATES IN FULL AT THE TIME OF SERVICE. IF WE PARTICIPATE WITH YOUR PLAN, COPAYS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF SERVICE AND YOUR PRIMARY INSURANCE WILL BE BILLED. YOU ARE RESPONSIBLE FOR BILLING ANY SECONDARY INSURANCES YOU HAVE AND YOU ARE RESPONSIBLE FOR ANY ADDITIONAL MONIES OWED AFTER WE RECEIVE YOUR INSURANCE COMPANY'S PAYMENT (IE: NON-COVERED SERVICES). OUR PROFESSIONAL SERVICES ARE RENDERED FOR AND CHARGED DIRECTLY TO YOU NOT YOUR INSURANCE COMPANY AND YOU AGREE TO BE RESPONSIBLE FOR PAYMENT. PAYMENT MAY BE MADE BY CASH, CHECK OR CREDIT CARD. IF WE ARE NOT A PARTICIPATING PROVIDER, A RECEIPT WILL BE GIVEN TO YOU SUITABLE FOR YOU TO SUBMIT TO YOUR INSURANCE CARRIER. YOU AGREE THAT COSMETIC AND OR NON-COVERED SERVICES WILL NOT BE BILLED TO YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT IN FULL BEFORE OR AT THE TIME OF SERVICE. OUTSIDE SERVICES SUCH AS LABORATORY SERVICES, RADIOLOGY SERVICES AND ANESTHESIA WILL BE BILLED TO YOU DIRECTLY.

SIGNATURE ON FILE: I, THE UNDERSIGNED, REQUEST THAT PAYMENT OF INSURANCE/MEDICARE BENEFITS BE MADE ON MY BEHALF TO MEADVILLE/VALLEY OPHTHALMOLOGY ASSOCIATES, FOR ANY SERVICES RENDERED TO ME BY THIS PRACTICE AND ITS PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY HEALTH INSURANCE COMPANY OR THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I ACKNOWLEDGE RECEIPT OF A COPY OF THIS OFFICE'S NOTICE OF PRIVACY AND PAYMENT POLICIES. I CONSENT TO EXAMINATION AND TREATMENT, AND I AGREE TO BE FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP (IF OTHER THAN PATIENT): _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THE NOTICE CONTAINS A PATIENT RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO RECEIVE A COPY OF OUR NOTICE BEFORE SIGNING THE ACKNOWLEDGMENT.THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE HAD THE OPPORTUNITY TO RECEIVE OUR NOTICE OF PRIVACY PRACTICES.

THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENTS, PAYMENTS OR HEALTH CARE OPERATIONS.
- THE PRACTICE RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY PRACTICES
- I HAVE THE RIGHT TO REQUEST RESTRICTIONS TO THE USES OF MY INFORMATION.THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS, BUT IF WE DO, WE WILL HONOR THESE RESTRICTIONS.

I AUTHORIZE MEADVILLE/VALLEY OPHTHALMOLOGY ASSOCIATIESTO DISCLOSE INFORMATION REGARDING MY MEDICAL CONDITION(S)/TREATMENT(S) TO:

PLEASE PRINT ALL THAT APPLY:

SPOUSE: _____

CHILD: _____

ANY OTHER: _____

IUNDERSTAND THAT IF I PROVIDE THE PRACTICE WITH A SECONDARY CONTACT, THE PRACTICE MAY CONTACT THAT PERSON WITH INFORMATION REGARDING MY APPOINTMENTS.

PATIENT SIGNATURE: _____ DATE: _____

REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT): _____

Meadville/Valley Ophthalmology Associates

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. Thank you for your cooperation.

DATE: _____

PATIENT NAME: _____ **D.O.B.** _____

LIST ANY MEDICATIONS YOU CURRENTLY TAKE, INCLUDING EYE MEDICATIONS (OR ATTACH LIST): _____

_____

MEDICATION ALLERGIES: (PLEASE LIST THE MEDICATION AND TYPE OF REACTION**)** _____

_____

LIST ALL MAJOR ILLNESSES OR INJURIES: (EX: DIABETES, HIGH BLOOD PRESSURE, STROKE, HEART ATTACK, GLAUCOMA, ETC.)

_____

LIST ANY SURGERIES YOU HAVE HAD: (EX: CATARACT, JOINT REPLACEMENT, APPENDECTOMY) _____

_____

DATE OF LAST EYE EXAM: _____ **DO YOU WEAR GLASSES? Y / N HOW OLD ARE THEY:** _____

DO YOU WEAR CONTACT LENSES? Y / N IF YES, WHAT TYPE: _____

FAMILY HISTORY: HAS ANY FAMLY MEMBER (PARENTS, SIBLINGS, GRANDPARENTS) HAD ANY OF THE FOLLOWING CONDITIONS?

DIABETES: Y / N RELATIONSHIP: _____ HIGH BLOOD PRESSURE: Y / N RELATIONSHIP: _____

STROKE: Y / N RELATIONSHIP: _____ GLAUCOMA: Y / N RELATIONSHIP: _____

BLINDNESS: Y / N RELATIONSHIP: _____ RETINAL DETACHMENT: Y / N RELATIONSHIP: _____

MACULAR DEGENERATION: Y / N RELATIONSHIP: _____ CATARACT: Y / N RELATIONSHIP:_____

PERSONAL SOCIAL HISTORY: PLEASE NOTE, THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER, YOU MAY DISCUSS THIS PORTION DIRECTLY WITH YOUR DOCTOR IF YOU PREFER: ☐ YES, I PREFER TO DISCUSS THIS PORTION WITH MY DOCTOR

OCCUPATION, IF EMPLOYED: _____ **DO YOU DRIVE? Y / N**
IF YES, ANY DIFFICULTY WHEN DRIVING? Y / N PLEASE EXPLAIN ANY DIFFICULTY: _____

DO YOU USE TOBACCO PRODUCTS? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG? _____

DO YOU DRINK ALCOHOL? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG? _____

DO YOU USE ILLICIT DRUGS, INCLUDING MARIJUANA? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG? _____

_____

In each area, if you are not having any difficulties, please check **"No Problems."** If you are **CURRENTLY** experiencing any of the symptoms listed, **please circle the ones that apply,** or explain any that may not be listed. If you have any questions about this, please ask one of the technicians.

CONSTITUTIONAL (General Health) ❑ **No Problems**, Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____
_____

EYES: ❑ **No Problems**, Loss of vision, blurred vision, distorted vision/ halos, double vision, pain, tearing, redness, light sensitivity, mucous discharge. Other: _____

ENT: ❑ **No Problems**, Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

CARDIOVASCULAR ❑ **No Problems**, Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

RESPIRATORY ❑ **No Problems**, Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____
_____

GASTROINTESTINAL ❑ **No Problems**, Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other: _____

GENITOURINARY ❑ **No Problems**, Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence, pregnant, breastfeeding. Other: _____

MUSCULOSKELETAL ❑ **No Problems**, Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

INTEGUMENTARY. (Skin, Hair & Breast) ❑ **No Problems**, Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

NEUROLOGICAL ❑ **No Problems**, Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:
_____

PSYCHIATRIC ❑ **No Problems**, Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

ENDOCRINOLOGICAL ❑ **No Problems**, Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

HEMATOLOGICAL ❑ **No Problems**, Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:
_____

IMMUNOLOGIC ❑ **No Problems**, Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV or other sexually transmitted diseases. Other:_____