

NEW PATIENT INFORMATION



First Name: _____ Middle Initial _____ Last Name _____

Nick Name: _____ Male or Female Age: _____

Mailing Address: _____ Date of Birth: _____

City: _____ Zip Code: _____ SSN: _____

Phone Number: _____ Employer: _____

Daytime Phone # _____ Occupation: _____

Cell Phone #: _____ Employed: Full Time or Part Time

Do you accept text messages? Yes or No Marital Status: _____

Email: _____ Spouse: _____

Language Preference English Spanish Please contact me by: Phone Email Mail

Race (Please circle): African American Native American or Alaska Native Asian
Caucasian/ White Hispanic Native Hawaiian/Other Pacific Islander

Parent or Guardian Name (if patient is under 18) _____

Please tell us how you heard about us:

- Facebook
- Internet (where?) _____
- Yellow Pages
- Friend/Relative (name?) _____
- Drove By
- Doctor (name?) _____
- Insurance Company
- Brochure/Flyer (from?) _____
- Yelp
- Other(Please specify) _____

Bill to: Name and Address (If different from patient) _____

Insurance Information

Insurance Company: _____ Subscriber ID: _____

Subscriber Information (if different than patient)

Name: _____ Birth Date: _____ SSN: _____

Male or Female Relationship to Patient: _____ Employer: _____

Vision Benefits? Yes or No If yes, through which company? _____

Please see reverse for medical history

Date of last eye exam: _____ Pregnant or Nursing: Yes or No

Primary Care Physician: _____ Referring Physician: _____

Do you currently wear contacts? Yes or No If no, would you like to try contacts? Yes or No

If yes, what kind? _____ Are you satisfied with them? Yes or No

What is the primary reason for your visit today? _____

Please list any previous eye surgeries: _____

Please list all medications (including over the counter): _____

Allergies to medications: _____

Tobacco Use: Yes or No Current or Past If yes, how much? : _____

Please list if you or a relative have ever been diagnosed or treated for the following:

Ocular History	Relationship	Medical History	Relationship
Cataracts	_____	Allergies	_____
Corneal Problems	_____	Asthma	_____
Diabetes	_____	Cancer	_____
Dry Eyes	_____	Cholesterol	_____
Eye Injuries	_____	Migraines	_____
Flashes of Light	_____	High Blood Pressure	_____
Glaucoma	_____	Lupus	_____
Macular Degeneration	_____	Stroke/TIA	_____
Ocular Allergies	_____	Hepatitis A B C (circle one)	_____
Double Vision	_____	Kidney Problems	_____
Cross/Eye turn	_____	Multiple Sclerosis	_____
Floaters	_____	Tuberculosis	_____
Retinal Issues	_____	Thyroid (hypo or hyper?)	_____
Other	_____	Other	_____

Do you... (please check if answer is yes)

- Work at a computer?
- Have sunglasses?
- Have problems with glare at night?
- Want lenses that change from light to dark?
- Want information about LASIK?
- Want to try colored contacts?
- Want information about no-line bifocals?
- Want more information about contacts?

Signature of Patient or Guardian: _____ Date _____

Patient's Name _____ Date of Birth _____
(Please print)

Cell Phone Number: _____ Texting ok? Yes or No

Email Address (please print legibly) _____

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to a 1.5% interest charge.**

Contact lens services are subject to additional fees that are not included below.

_____ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

_____ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is \$39), co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

_____ 3. **Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services such as the **refraction (\$20)** and the **Optomap (\$39)**.

I have read and I agree to the financial policy information stated above that applies to me.

Patient (or responsible party) signature

Date

Person signing on behalf of patient (please print name)

Relationship to patient

Please see reverse for HIPAA Consent



HIPAA Consent: Patient Privacy

We are required by law to protect the privacy of your medical information, and to provide you with written notice describing how medical information about you may be used and disclosed, and how you can access this information.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances, we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time.

You have the right to receive a copy of our most current Notice of Privacy Practices in effect. If you wish to receive a copy, please ask at the front desk, and we will provide you with a copy.

I consent to Eyecare Associates of Southern Oregon, PC's Notice of Privacy Practices

Patient Name: _____

Signature: _____ Date: _____

Please list anyone you wish to have access to your records:

1. _____ 2. _____

Brian K. Mitchell, O.D. Tessa C. Johnston, O.D. Kurt Wilkening, O.D. Damon Hanson, O.D.

935 Royal Ave Medford, OR 97504 541-779-2211 www.ecaofmedford.com