carteret VISION center

Thank you for supplying us with the following information. If you are a returning patient, we apologize for the added paperwork, but new regulations require us to get additional information that we may not have obtained in the past. If you are a new patient — Welcome! — We are pleased you have chosen our office for your eye care needs!

Patient Information

Name: _____ Nickname: _____
First Last M.I. (if different)

Mailing Address: _____ _____
Street Address Apt #

_____ _____ _____
City State Zip Code

Date of Birth: _____ Social Security #: _____ Sex: ☐ M ☐ F

Language: _____ Race: _____ ☐ Hispanic ☐ Not Hispanic

Marital Status: ☐ Single ☐ Married Name of Employer: _____

☐ PT

☐ Other _____ ☐ FT Position: _____

Contact Information

Primary Phone: _____ Secondary Phone: _____
☐ Cell ☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work

Can we leave a message regarding your medical care and test results? ☐ Yes ☐ No Preferred Method of Contact: ☐ Call ☐ Text

Email: _____

Responsible Party – If the patient is under 18 the guardian will be listed as guarantor. If housed at a medical facility list contact information here. Relationship to Patient: _____

Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____

Address: _____ _____ _____
☐ Same As Patient Street Address Apt # Zip Code

_____ _____ _____
City State Zip Code

Contact Information Acknowledgement

I understand that texts, emails, and phone messages may not meet the HIPPA compliance standards if I elect for their use. I provide permission for Carteret Vision to contact me in the following ways:

☐ All ☐ Phone ☐ Text ☐ Email ☐ Traditional Mail

Initial:

Insurance Information

NOTE: If patient's relationship to policy holder is self, you do not need to fill out policy holder information, just the first two lines and check the box for self.

Vision Insurance

Insurance Company: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Policy Holder's Social Security #: _____ Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance (Primary)

Insurance Company: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Policy Holder's Social Security #: _____ Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance (Secondary)

Insurance Company: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Policy Holder's Social Security #: _____ Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Eye Care History

☐ Glasses

When was your last eye exam? _____ Do you currently wear glasses or contacts? ☐ Contacts

Name of Office: _____ Name of Doctor: _____

Reason for Your Visit (please include any problems, concerns, or changes concerning your eyes or vision) :

_____

_____

List of Current Medications: **If you have a medication list please give it to the front desk, so we can make a copy!**

Medication Allergies:	Other Allergies:

Patient Eye Surgery and Medical Condition History

Type of Surgery: _____ Type of Surgery: _____

Date of Surgery: _____ Date of Surgery: _____

☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Please select any of the following medical conditions that apply or have applied to you:

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Dry Eyes ☐ Frequent Eye Infection

Alcohol Use: ☐ Consume Daily ☐ Consume Occasionally ☐ Former Drinker ☐ Never Drink

Tobacco Use: ☐ Daily Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Family History

Please select any of the following medical conditions that apply or have applied to your immediate family members:

	Mother	Father	Siblings	Children
High Blood Pressure:	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐
Thyroid Disease:	☐ Hyper ☐ Hypo	☐ Hyper ☐ Hypo	☐ Hyper ☐ Hypo	☐ Hyper ☐ Hypo
Diabetes:	☐ Type 1 ☐ Type 2	☐ Type 1 ☐ Type 2	☐ Type 1 ☐ Type 2	☐ Type 1 ☐ Type 2
Glaucoma:	☐	☐	☐	☐
Cataracts:	☐	☐	☐	☐
Macular Degeneration:	☐	☐	☐	☐

Patient Health Information

Height: _____ Weight: _____ Are you currently pregnant? ☐ Yes ☐ No

Primary Care Facility: _____ Location: _____

Primary Care Physician: _____ Phone: _____

By providing the above information you are giving our office permission to share demographic and medical information with the provider or facility listed upon their request.

Pharmacy: _____ Location: _____

Consent to Examine

Dr. Christensen has permission to examine myself/my child to ensure ocular health. I understand that treatment recommendations will be explained simply and clearly and that I am encouraged to ask questions until I fully understand the recommendations. Dr. Christensen has my permission to share records with my primary care physician or referring specialists as needed.

Initial:

Contact Lens Acknowledgement

I understand that, per North Carolina State Law, a contact lens fitting is required annually before myself/my child can obtain contact lenses or a contact lens prescription. I understand that the services provided during a routine examine DOES NOT include a contact lens fitting and choosing to try contact lenses via personal preference or professional recommendation may result in an additional charge. I fully understand that a contact lens fitting may be completed on a different date than my/my child's routine exam, but must be completed within 90 days of my exam. I understand that requesting a contact lens fitting 90 days after an eye exam requires a second complete eye exam to be conducted, and I will be held financially responsible for all services rendered that are not covered by my insurance company.

Initial:

Insurance Consent

I authorize Carteret Vision Center to file and request assignment of benefits from my insurance company(s). I hereby authorize my insurance to be paid directly to Carteret Vision Center for services and materials received. I understand that copays and fees for non-covered services will be collected and may not apply toward my/my child's deductible. I understand that payment may not be collected on the date of my service and accept financial responsibility for all non-covered services and remaining costs. I also authorize Carteret Vision Center to release any information provided, if required by my insurance company(s).

Initial:

HIPPA- Notice of Privacy Practice

Carteret Vision Center offers a complete Notice of Privacy Practice to each patient that can be found behind this form, please review it carefully before signing this form. If you cannot locate the form, please request a copy from our front desk or refer to the patient portal on our website. The HIPAA Privacy Rule gives patients a right to be informed of the privacy practices of health care providers and health plans as well as patients' privacy rights regarding their personal health information. Our facility is required to provide a notice that is a clear, user-friendly explanation of these rights and practices. If you would like further information regarding any of the information in the Notice of Privacy Practice Brochure, please see a Carteret Vision Employee.

By signing the line below I acknowledge that a copy of the Notice of Privacy Practice has been made available to me and agree to the use of the personal and medical information provided, as disclosed in the notice.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____