East Fishkill Eye Care

857 Route 82 Hopewell Junction NY 12533 – T (845) 227-2233 F (845) 227-4186

Welcome! Thank you for choosing our practice for your eye care. We strive to provide personal and caring medial service in an atmosphere of respect and privacy. If you have any questions or concerns, please do not hesitate to ask for help at any time. To help serve you better, please answer the following questions.

PATIENT REGISTRATION RECORD

Patient Legal Name (Last, First, Middle)	Preferred First Name	Date of Birth	Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them
Mailing Address	City, State		Zip Code
Home Phone	Cell Phone	Work Phone	
Email for reminders	Occupation? Student?	Where do you work? Name of school?	
Name of person to notify in an emergency	Relationship	Phone number	

How did you find our office?	CIRCLE YES OR NO:
☐ Friend/Co-worker ☐ Drive By ☐ Insurance Provider ☐ Other:	- Have you traveled outside of the state in the last 14 days? YES NO - If so, where? _____ - Have you attended any gathering with more than 10 people? YES NO - Have you been in contact with anyone known to have COVID-19? YES NO - Have you been asked to self-quarantine? YES NO - Do you currently have a fever or lower respiratory symptoms such as a cough, shortness of breath or any flu like symptoms? YES NO

INSURANCE INFORMATION

Name of Major Medical Insurance	Name of Insured	Relationship to Patient	Date of Birth
Medical Card ID #	Group # (if any)		
Vision Plan Name for Glasses/Contacts (VSP/Eyemed)			

PLEASE READ & SIGN. Routine eye exams, refraction (glasses prescription), contact fitting or contact lenses, may not be covered by insurance. In these cases the patient is responsible for payment. A referral is not a guarantee of payment. It is your responsibility to know your coverage. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits paid and not paid by the insurance.

Signed _____ Date _____

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When was your last eye exam?

Name of your past/current eye doctor?

Name of your personal physician?

What city?

Phone number?

Please list your medications: (including vitamins, creams, inhalers, sprays & injections)

Any allergies to medications? (please list)

Please list eye medications including OTC and supplements:

Name and location of pharmacy:

Do you smoke, vape or use tobacco? Y/N
Are you a former smoker? Y/N

Do you want a contact lens exam?

- ☐ Yes. I wear contacts and would like to continue.
- ☐ Yes. I would like to try them.
- ☐ Yes. I would like to restart wearing them.

Do you experience any of the following?

- ☐ Computer-related eye strain
- ☐ Halos while driving at night
- ☐ Sensitivity to sunlight

Does anyone in your family have?

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disorder
- ☐ Cataracts
- ☐ OTHER:

Do you have any special eyewear needs?

- ☐ Water sports (snow/sailing/fishing)
- ☐ Safety glasses (lawn work/ wood work)
- ☐ Swimming
- ☐ Racquet sports/baseball/basketball

Check if you have or experience any of the following:

- ☐ Accutane medication
- ☐ Acne Rosacea
- ☐ Asthma
- ☐ Asthma medication
- ☐ Autoimmune disease
- ☐ Blood disorder (Anemia/Leukemia)
- ☐ Bronchitis/Emphysema
- ☐ Bumps on eyelid margin(s)
- ☐ Burning sensation in eye(s)
- ☐ Cancer
- ☐ Chronis obstructive pulmonary disease
- ☐ Color blindness
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetes when pregnant
- ☐ Discharge from eye(s)
- ☐ Difficulty breathing
- ☐ Digestive problems
- ☐ Double vision
- ☐ Dry eye(s)
- ☐ Eye injury
- ☐ Eye surgery
- ☐ Feeling of something in eye(s)
- ☐ Fatigue
- ☐ Flashes of light
- ☐ Floaters in your vision
- ☐ Fluctuating vision
- ☐ Glaucoma
- ☐ Gritty/sandy feeling in eye(s)
- ☐ Headaches
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV
- ☐ Hormonal dysfunction
- ☐ Itchy eye(s) or eyelid(s)
- ☐ Joint pain
- ☐ Lazy eye or eyelid
- ☐ Kidney problems
- ☐ Light sensitivity
- ☐ Liver problems
- ☐ Lupus
- ☐ Migraines
- ☐ Muscle pain
- ☐ Multiple Sclerosis
- ☐ Numbness
- ☐ Recent weight loss/gain
- ☐ Red eyes
- ☐ Retinal tear/detachment
- ☐ Rheumatoid arthritis
- ☐ Sarcoidosis
- ☐ Sinus infection
- ☐ Sleep apnea
- ☐ Sjogren's disease
- ☐ Skin problems
- ☐ Stroke/Vascular disease
- ☐ Swollen eye(s) or eyelid(s)
- ☐ Thyroid problems
- ☐ Watering/watery eye(s)

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ALL CO-PAYS, DEDUCTIBLES AND PAYMENTS ARE DUE AT THE TIME OF SERVICE.

FOR MEDICARE PATIENTS ONLY: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made on my behalf to East Fishkill Eye Care for any services furnished me by the listed provider / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. As Medicare Participating Providers, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (please print)	Provider, Name & Address
Patient's Signature	East Fishkill Eye Care LLC 857 Route 82 Hopewell Junction NY 12533
Patient's Medicare #	

ALL OTHER INSURANCE PLANS / ASSIGNMENT OF BENEFITS

Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to East Fishkill Eye Care I am hereby informed that my claim may be billed electronically to my Insurance Carrier or via the Internet.

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, to my insurance company, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. This assignment/consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations. For additional information on your insurance company's Patient Confidentiality Policy, please refer to their website and/or benefits provider.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY FOR PAYMENT OF FEES AND THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES.

Patient's / Parent's Signature Date

East Fishkill Eye Care

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996, I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP CARE AMONG THE MULTIPLE HEALTH CARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY.

- OBTAIN PAYMENT FROM DESIGNATED THIRD PARTY PAYERS.

- CONDUCT NORMAL HEALTH CARE OPERATIONS SUCH AS QUALITY ASSESSMENTS OR EVALUATIONS AND PHYSICIAN CERTIFICATIONS.

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION (AVAILABLE IN THE OFFICE IN PRINT-FORM.) I HAVE REVIEWED SUCH NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT AND ACKNOWLEDGE THAT I HAVE STUDIED THE PRIVACY PRACTICES. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME, AND I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICES OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT THIS ORGANIZATION RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THE ORGANIZATION IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF THE ORGANIZATION DOES AGREE, THEN IT IS ABOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS TAKEN ACTION RELYING THIS CONSENT.

PRINT NAME _____

SIGN NAME _____ DATE _____