TRIAD EYE INSTITUTE

Patient Registration

Patient Name: ______ DOB / Age: ______

Email Address: ______ SSN: ______

Address: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______

Preferred method of contact: ☐Home ☐Cell ☐ Work

May we have permission to leave medical information on your voice mail? ☐No ☐Yes

May we text you appointment reminders? ☐No ☐ Yes

Employment / Student Status: ______ Marital Status: ______

Employer: ______ Work Phone: ______

Spouse's Name: ______ Spouse's DOB: ______

Spouse Employer: ______

Race:
☐African American
☐American Indian or Alaska Native
☐Asian
☐Black
☐Native Hawaiian or Other Pacific Islander
☐White
☐Unspecified

Ethnicity:
☐Hispanic or Latino Spanish
☐Not Hispanic or Latino
☐Unspecified

Preferred Language:
☐English
☐Spanish
☐Unspecified
☐Undetermined

Birth Gender:
☐Male
☐Female
☐Declined

Gender Identity:
☐Identifies as male
☐Identifies as female
☐Female-to-male/ Transgender male
☐Male-to-female/ transgender female
☐Genderqueer, neither exclusively male nor female
☐Additional gender category or other: ______
☐Declined

Sexual Orientation:
☐Lesbian, gay or homosexual
☐Straight or heterosexual
☐Bisexual
☐Other: ______
☐Don't Know
☐Declined

Emergency Contact

Name: ______ Address: ______

Phone: Relationship to Patient:

Person Responsible for Payment (if same as patient leave blank)

Name: ______ DOB: ______ Relationship to Patient: ______

SSN: Employer:

Home Phone: Cell Phone: Work Phone:

TRIAD EYE
INSTITUTE

Insurance Information

Primary Insurance Company Name: ______________ Address: ______________

Policy Number: ______________ Group Number: ______________

Subscriber Name: ______________ DOB: ______________ Relationship to Patient: ______________

Secondary Insurance Name: ______________ Address: ______________

Policy Number: ______________ Group Number: ______________

Subscriber Name: ______________ DOB: ______________ Relationship to Patient: ______________

Referral Information

Do you currently reside in a skilled nursing facility? ______________

Are you currently receiving Hospice care? ______________

Primary Care Physician Name: ______________

Who is your current eye doctor? ______________

How were you referred here today? ______________ Date of Last Visit: ______________

If you schedule surgery do you have a surgeon preference? ______________

Do you have a power of attorney? ______________

Preferred Pharmacy and ePrecribing Consent

I agree that Triad Eye Institute may request and use my prescription medications history from other healthcare providers or third party pharmacy benefits payers for treatment purposes.

Patient Signature: ______________ Date: ______________

Preferred Pharmacy: ______________ City: ______________ Phone: ______________

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Triad Eye Institute, for services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature: ______________ Date: ______________

Acknowledgement of Receipt of notice of Privacy Practices

I have received a copy of Triad Eye Institute's notice of privacy practices. I also give permission to Triad Eye Institute to release my protected health information to the following people, if requested by such:
(list names in the spaces provided)

______________ ______________ ______________ ______________

Print Name: ______________ Signature: ______________ Date: ______________

Patient Name: ____________________ DOB: ____________________

Reason for your visit?

Eye History: (Check all that apply)

☐Dryness	☐Floaters	**Do you currently wear?**
☐Irritation	☐Tearing	☐Glasses
☐Itching	☐Retinal Detachment	☐Contacts:
☐Decreased Vision	☐Cataracts	☐Soft or ☐RGP (Hard) Last Worn:

Medications list any medications and dosage: (including non-prescription)

Past Medical History:

☐Thyroid Disease	☐High Blood Pressure		☐Diabetes:	
☐Heart Disease	☐Hepatitis	Type:	☐Type 1	☐Type 2
☐Glaucoma	☐Macular Degeneration		☐Insulin	☐Non-Insulin
☐HIV	☐None	BS: ________	Time: ________	

☐TB Yr. Diagnosed. ________ Active: ☐ Yes ☐ No Last A1C: ______ Date: ________ Yr. Diag: ________

Influenza Immunization Received? ☐Yes ☐No If yes date received: ____________

Pneumococcal Vaccination Received? ☐Yes ☐No If yes date received: ____________

List any other past medical conditions not listed above: ____________________

Medication Allergies

Are you allergic to any medication? (if yes, please list medication name and reaction) ☐Yes ☐No

Preferred Pharmacy: ____________________

Have you had any of the following eye surgeries? List the year the surgery was performed and what doctor performed the procedure

☐Cataracts	Doctor: ________	Year: ________	☐RK	Doctor: ________	Year: ________
☐RLE	Doctor: ________	Year: ________	☐LASIK	Doctor: ________	Year: ________
☐YAG Laser	Doctor: ________	Year: ________	☐Corneal	Doctor: ________	Year: ________
☐PRK	Doctor: ________	Year: ________	☐ICL	Doctor: ________	Year: ________
☐Other:			☐None		

Family History

Do you have any family history of the following? (If yes, please note the relationship to the patient)

☐Glaucoma	________	☐High Blood Pressure	________
☐Diabetes		☐Macular Degeneration	

Social History

Smoking Status	☐Current	☐Never	☐Former	
Alcohol Use	☐Never	☐Rarely	☐Moderate	☐Daily

Review of Systems

Do you have any of the following TODAY? (Check all that apply)

Gastrointestinal	☐Heartburn / Reflux	☐Nausea / Vomiting / Diarrhea		☐None
HENT	☐Hay fever / Allergies / Congestion	☐Sinusitis	☐Neck Problems	☐None
Cardiovascular	☐Chest Pains / Discomfort	☐Palpitations		☐None
Neurological	☐Headaches/ Migraines	☐Weakness		☐None
Respiratory	☐Cough / Wheeze	☐Shortness of Breath		☐None
Musculoskeletal	☐Muscle/ Joint Pain	☐Swollen Joints		☐None
Genitourinary	☐Leaking Urine	☐Bloody Urine		☐None
Psychiatric	☐Anxiety / Stress	☐Depression	☐Psychiatric illness	☐None
Blood/ Lymphatic	☐Blood Disease	☐Unexplained Lumps		☐None
Integumentary	☐Rash			☐None
Female Only: Are you currently pregnant or nursing?	☐Yes	☐No		