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:
☐American Indian / Alaskan Native
☐Asian
☐Black / African American Native Hawaiian / Other pacific Islander
☐White
☐Unknown
☐Declined to answer

Ethnicity:
☐Hispanic Origin
☐Non-Hispanic Origin
☐Unknown
☐Declined to Answer

Preferred Language:
☐English
☐Spanish
☐Other:

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? _____

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: _____

Height: _____ Weight:: _____

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:

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: _____

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			

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

_____

_____

Medication Allergies

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

_____

Preferred Pharmacy:

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
Fall Risk	☐No	☐Yes	☐Patient not ambulatory	

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	