# PATIENT REGISTRATION & MEDICAL HISTORY

Last Name ______________________ First Name _________________ M.I. _____ Preferred Name____________________

Mailing Address ________________________________ City _________________ State________ Zip Code___________

Marital Status S M W D O Birth Date _____________ Age ________ Social Security # ________________________

Home Phone _________________ Cell Phone ________________ E-mail Address_______________________________

Employer ___________________________________ Occupation _______________________________________________

Referred By _______________________ Family Physician _____________________________________________________

Previous Eye Doctor ________________________________________________________________________________

**IF MINOR:** Mother's Name _________________________ Father's Name ________________________________________

**Insurance Information**

Do you have vision insurance? ○ Yes ○ No Do you have health insurance? ○ Yes ○ No

Vision Insurance ______________________________ Policy Holder ______________________ DOB_________________

Primary Insurance _____________________________ Policy Holder ______________________ DOB _________________

Secondary Insurance___________________________ Policy Holder ______________________ DOB _________________

Relationship to Policy Holder _________________________ Policy Holder's Social Security# ________________________

**Medications**

**List any medications or eye drops you are allergic to** _________________________________________________

**List current medications (Prescription or Over-the Counter)** ___________________________________________

_______________________________________________________________________________________________

☐ See Attached List

## Health & History

**Your Health**

*Have you ever had or do you have….*

- ○ Allergies
- ○ Auto Immune Disorder
- ○ Diabetes
- ○ Cancer
- ○ Headaches
- ○ Drug Reaction
- ○ Heart Disease
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Thyroid Disease
- ○ Eye Surgery__________________
- ○ Glaucoma
- ○ Macular Degeneration
- ○ Other ______________________________
- ○ None of the Above

**Family History**

*Has anyone in your family ever had*

- ○ Diabetes
- ○ Glaucoma
- ○ Blindness
- ○ Cataracts
- ○ Lazy Eye
- ○ Macular Degeneration
- ○ Other
- ○ None of the Above

**Vision Needs**

*Do you do the following?*

- ○ Fishing
- ○ Crafts/Sewing
- ○ Gardening
- ○ Computer
- ○ Read Books
- ○ Golf
- ○ Team Sports
- ○ Music
- ○ Shooting
- ○ Racquet Ball
- ○ Skiing
- ○ Welding
- ○ Woodshop
- ○ Water Sports
- ○ Other __________________________
- ○ None of the Above

**Social History**

*Do you…*

- ○ Smoke
- ○ Consume Alcohol
- ○ Use Street Drugs
- ○ None of the Above

**PATIENT SIGNATURE** ________________________________________________ **DATE** _______________________

**Kimberly A Schmidt, OD**
333 S State Street, Suite T
Lake Oswego, OR 97034
P 503.636.2762 F 503.636.4502

## HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent inwriting at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we email you?

**Yes** **No**

Do you prefer messages on your home or cell?

**Home** **Cell** **Both**

May we discuss your medical condition with any member of your family?

**Yes** **No**

If Yes, please name the members allowed:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Print Patient Name: ____________________________________________

Signature: ____________________________________________ Date: ______________________

Witness: ____________________________________________ Date: ______________________

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# Patient Insurance Waiver Form/Agreement to Pay

I understand that by signing this agreement, I am authorizing the physician, optician, and staff at Schmidt EyeCare to perform my requested optical and/or medical procedures.

I understand that every effort will be made to bill my insurance for the services rendered. In the event of insurance denial to pay, I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurance has paid. I understand that refractions and contact lens exams are elective procedures that insurance will not pay for.

I give valid consent of the release of all medical record documentation to any insurance company for determination of reimbursement for the exam services. I also authorize the release of my insurance benefit information to help in the reimbursement process. My consent is valid for whatever time frame necessary until further notice.

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Patient Name

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Patient Signature Date