

**RHODE EYELAND LLC
Jacqueline Boisvert, OD
74 Frenchtown Road
North Kingstown, RI 02852**

PATIENT INFORMATION:

Name: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____ SSN: _____
Home telephone: _____ Work: _____ Cell: _____
Email Address: _____ Best way to reach you: _____
Consent for patient portal? Yes/No May we leave a message on your phone? Yes/No
Emergency Contact: _____ Telephone #: _____
Pharmacy Name and Location: _____
May we send prescriptions electronically to your pharmacy? Yes/No

INSURANCE INFORMATION:

Primary Insurance Company: _____
Member ID #: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance Company: _____
Member ID #: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered at time of service. I authorize the release of any information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I understand that Rhode Eyeland LLC will not resubmit a claim to an insurance company not disclosed at the time of appointment.

I am fully aware that I am responsible for any and all charges not covered by my insurance at today's visit. This includes, but is not limited to:

- History
- Eye Examination
- Refraction
- Contact Lens Examination
- Any Screenings – including, but not limited to:
 - Visual Acuity, Color Blindness, Amsler Grid, Pupillary Distance
- Any Testing – including, but not limited to:
 - Auto-Refracton, OCT Scanning, Fundus Photography, Visual Field Testing
- Any Procedures or Treatments – including, but not limited to:
 - Corneal Abrasions, Epilation, Punctal Plugs, Foreign Body Removal, Bandage or Therapeutic Contacts
- \$50 charge for any missed appointments

Signature: _____ Date: _____

Relationship to patient: Self Parent Power of Attorney

____ I **HAVE** PROVIDED A COPY OF MY INSURANCE CARD Initials: _____

____ I **HAVE NOT** PROVIDED A COPY OF MY INSURANCE CARD Initials: _____

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Name: _____ DOB: _____

Why do you need an eye exam today? _____

When was your last eye exam? _____ Where? _____

Primary Care Physician: _____ When was your last physical? _____

What medical conditions do you have? _____

Do you smoke? Never Smoker Former Smoker Current Smoker How much? _____

Do you drink alcohol? Yes / No How much? _____ Daily/Weekly/Rarely

How much do you weigh? _____ How tall are you? _____

Are you allergic to any medications, foods, latex, or dyes? _____

Medical Family History _____

Is there anything else about your medical health that we should know? _____

Do you experience any of the following? (circle all that apply)

- | | | | |
|-----------------------|---------------------------|----------------------|-----------------------|
| Poor Vision | Cough | Rash/Hives | Rapid Heartbeat |
| Eye Pain | Congestion | Changing Moles | Anemia |
| Tearing | Wheezing | Allergies | High Blood Pressure |
| Red eye | Shortness of breath | Hay Fever | Bleeding |
| Temporary vision loss | Headache | Arthritis | Thyroid Abnormalities |
| Fever/Chills | Jaw pain/Scalp tenderness | Joint Pain/Stiffness | Diabetes |
| Stuffy nose | Seizure | Upset Stomach | Insomnia |
| Ear ache | Stroke | Diarrhea | Urinary Frequency |
| Weight loss | Paralysis | Constipation | Burning on Urination |
| Dry mouth | Anxiety/ Depression | Incontinence | |

Please indicate all that apply:

- | | |
|-------------------------------------------------------------|-----------|
| Allergic to Adhesives or Lidocaine? | Yes or No |
| Using Blood Thinners or Flomax? | Yes or No |
| Have a Pacemaker, Defibrillator, or Artificial heart valve? | Yes or No |
| Have you been exposed to or had Ebola or MRSA? | Yes or No |
| Pregnant or planning to become pregnant? | Yes or No |
| Are you pre-medicating for any upcoming surgeries? | Yes or No |

May we electronically import prescriptions from your pharmacy? Yes/No

Please list your Medications & any Supplements you are taking.

Signature: _____ Date: _____

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MEANINGFUL USE: (circle as appropriate)

- | | | | | |
|-------------------|-------------------------|---------------------------|----------------------------------|----------|
| 1. Gender: | Male | Female | | |
| 2. Ethnicity: | Non-Hispanic/Non-Latino | Hispanic/Latino | Native Hawaiian/Pacific Islander | |
| 3. Communication: | Email | Mail | Telephone | |
| 4. Language | English | Spanish | French | Japanese |
| 5. Race: | White | Hawaiian/Pacific Islander | | |
| | Hispanic | African American/Black | | |
| | Asian | | | |

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PRINTED PATIENT NAME: _____

YOUR RELATIONSHIP TO PATIENT: Self Parent Power of Attorney

PRINT YOUR NAME (if not patient): _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Name	Date
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