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: __________________ Cell: ____________________ Work: __________________

Email Address: ___________________________________ Best way to reach you: _______________

Consent for patient portal? Yes/No May we leave a message? 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: __________________

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

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 I will be responsible for services not covered by my insurance plan. I understand that Rhode Eyeland LLC will not resubmit a claim to an insurance company not disclosed at the time of appointment.

Signature: ____ Date: __________________

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Name: ____ **DOB:** ______________________

***Why are you here 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**

***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?** ______________________________

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

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**

Please list your Medications & any Supplements you are taking.
____

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

Poor Vision	**Headache**	**Rash**
Eye Pain	**Seizure**	**Changing Moles**
Tearing	**Stroke**	**Allergies**
Ocular Redness	**Paralysis**	**Hay Fever**
Loss of Vision	**Anxiety**	**Hives**
Fever	**Depression**	**Anemia**
High Blood Pressure	**Arthritis/Joint Pain**	**Diabetes**
Rapid Heartbeat	**Thyroid Abnormalities**	

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Signature: ____ Date: ____________________

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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.

PATIENT NAME: ____

RELATIONSHIP TO PATIENT: ____

SIGNATURE OF PATIENT: ____

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