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-Refraction, 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

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 ACKNOWLEDGEMNT:

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