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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PATIENT HISTORY FORM

Name: _____ DOB: _____

Why are you here today? _____

When was your last eye exam? _____ Where? _____

Do you wear glasses? _____ Do you wear contact lenses? _____

What eye drops do you use? _____

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

What medical conditions do you have? _____

What is your family medical history? _____

Do you smoke? Never Smoker Former Smoker Current Smoker

Packs/Day: _____ When did you start? _____ When did you quit? _____

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

Have you had this year: **flu vaccine: Y/N Pneumonia vaccine: Y/N- Herpes Zoster (Shingles) vaccine: Y/N**

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 or you would like to share? _____

_____

PLEASE LIST YOUR MEDICATIONS AND NONPRESCRIBED SUPPLEMENTS

_____
_____
_____
_____
_____

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Name: _____

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

Poor vision	Rapid heartbeat	Headache
Eye pain	Congestion	Seizure
Tearing	Wheezing	Stroke
Ocular redness	Shortness of breath	Paralysis
Jaw pain	Upset stomach	Anxiety
Scalp tenderness	Diarrhea	Depression
Loss of vision	Constipation	Insomnia
Fever	Burning on urination	Diabetes
Chills	Urinary frequency	Thyroid abnormalities
Weight loss	Incontinence	Bleeding
Stuffy nose	Joint pain	Anemia
Ear ache	Stiffness	Allergies
Cough	Arthritis	Hay fever
Dry mouth	Rash	Hive
High blood pressure	Changing moles	

Are you: (indicate all that apply)

Allergic to: adhesives or lidocaine	Yes	No
Using: blood thinners or Flomax	Yes	No
Do you have: a pacemaker, defibrillator, artificial heart valve or artificial joints	Yes	No
Have you been exposed to or had: Ebola or MRSA	Yes	No
Pregnant or planning to become pregnant?	Yes	No
Are you pre-medicating for any upcoming surgeries?	Yes	No

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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 Reason