NORMANDY OPTICAL-PATIENT REGISTRATION
(PLEASE PRINT LEGIBLY)

Today's Date: ____________________

Patient Name
(Mr., Mrs., Miss., Ms., Mstr.): Last ____________ First ____________ Middle ____________

Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Home Phone: (   ) ____________ Work Phone: (   ) ____________

Cell Phone: (   ) ____________ E-mail Address: ____________________

Patient Social Security #: ____________ Patient's Date of Birth: ____________

If a **MINOR**, name of parent or guardian: ____________________

Marital Status: ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED Sex: ☐ M ☐ F

Spouse's Name: ____________________

Referred By: ____________________

Insurance Information (Must Be Completed)

Medicare #: ____________ Medicaid # ____________

BCBS #: ____________ Group #: ____________

Insurance Co: ____________ Phone #: ____________

Group #: ____________ ID #: ____________

Insured's Name: ____________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Insured's Employer: ____________ Employer's Phone #: ____________

Insured's Social Security #: ____________________

Insured's Date of Birth: ____________ Insured's Sex: ☐ M ☐ F

Person responsible for payment: ____________________

If Patient has any other insurance or any **VISION PLAN** please fill-in here: ____________________

Family Physician ____________ Phone #: ____________ Fax #: ____________

In case of emergency please contact (spouse relative, friend, or neighbor):

____________________ Phone #: ____________

I authorize the Release of Medical Information to process this claim and I authorize payment of Medical Benefits to Normandy Optical.

Patient's Signature: ____________________ Date: ____________

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, DIRECT PAYMENT REQUEST, AUTHORIZATION TO RELEASE MEDICAL INFORMATION, AND PATIENT CERTIFICATION

"One Time Authorization Agreement"

FINANCIAL RESPONSISBILITY: Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We therefore, urge you, the patient, to please check with your insurance company prior to any procedure. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Pease remember your insurance policy is between you and your company, not the insurance company and the doctor. I agree to pay, in full, and all charges for services not otherwise covered by insurance or other benefits.

DIRECT PAYMENT: I authorize direct payment to Normandy Optical of all benefits otherwise payable to me for care and treatment but not to exceed its regular charges, and I assign those benefits to Normandy Optical

AUTHORIZATION: I authorize any holder or information concerning my treatment and/or Durable Medical Equipment to release that information to the Social Security Administration and its intermediaries, the insurance carriers or other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information relating to treatment for serious communicable diseases (as defined by the Michigan Public Health Code), to my Health Plan Administrator, its agents and representatives, insurance carriers or its authorized agent, for the purpose of conducting concurrent or retrospective medical review of treatment and services provided by/at Normandy Optical.

CERTIFICATION: I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

____ ____________________

Signature of Patient — Date

____ ____________________

Signature of Responsible Party if Patient is a Minor or Unable to sign — Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received notice of the office's Notice of Privacy Practices.

__________________________ __________________________

Patient Signature — Witness

__________________________ __________________________

Print Name — Date

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

On ____________, when presented with the Acknowledgement of Receipt of Notice of Privacy Practice Form
Date

________________________ (the "Patient"), refused to provide a signature when requested.
Patient's Name

PATIENT INFORMATION FORM

PATIENT: ______________________ Date of Birth: ______________

Last First

HISTORY

Chief Complaint: ______________________

History of Present Illness:

- Location ______________ (Where is the pain/problem?)
- Quality ______________ (Example: color of)
- Severity ______________ (How severe is the pain/problem?)
- Duration ______________ (How long have you had this pain/problem?
- Timing ______________ (Does this pain/problem occur at a specific time?)
- Context ______________ (Where were you at the onset of this pain/problem)
- Associated signs/symptoms ______________ (What other associated problems have you been having?)
- Modifying factors ______________ (What makes the pain/problem worse or better? or Have you had any previous episodes?)

PATIENT MEDICAL HISTORY			FAMILY MEDICAL HISTORY		WHOM
Cataract	NO	YES	NO	YES	
Diabetes	NO	YES	NO	YES	
Glaucoma	NO	YES	NO	YES	
Mac Degeneration	NO	YES	NO	YES	
Hypertension	NO	YES	NO	YES	
Cancer	NO	YES	NO	YES	
Thyroid	NO	YES	NO	YES	
Heart Disease	NO	YES	NO	YES	
Arthritis	NO	YES	NO	YES	

PATIENT SOCIAL HISTORY

Birth Order: ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Five or > ☐ Only ☐ Twin

Use of Alcohol: ☐ Never ☐ Socially ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Current, packs/day: ______

Use of Drugs: ☐ Never Type/Frequency: ______

Venereal Disease: ☐ Yes ☐ No

MEDICATIONS **OCULAR TRAUMA OR OCULAR SURGERY**

- Constitutional Symptoms

Good General Health Lately	No	Yes
Fever	No	Yes
Headaches	No	Yes

- Eyes

Loss of Vision	No	Yes
Blurred Vision	No	Yes
Eye pain or soreness	No	Yes
Redness	No	Yes
Glare/light sensitivity	No	Yes
Mucous Discharge	No	Yes
Dryness	No	Yes
Burning	No	Yes
Double Vision	No	Yes
Foreign Body Sensation	No	Yes
Itching	No	Yes
Tearing	No	Yes
Floaters	No	Yes
Flashing lights	No	Yes
Fluctuating Vision	No	Yes
Lazy Eye	No	Yes
Chronic Infection of Eye or Lid	No	Yes
Prominent Eye	No	Yes
Distorted Vision	No	Yes

- Ears/Nose/Mouth/Throat

Hearing Loss or Ringing	No	Yes
Chronic Sinus Problem or Rhinitis	No	Yes
Swollen Glands in Neck	No	Yes

- Cardiovascular

Heart Trouble	No	Yes
Chest Pain or Angina Pectoris	No	Yes
Palpitation	No	Yes
Shortness of Breath; Walking or Lying Flat	No	Yes
Swelling of Feet, Ankles, or Hands	No	Yes

- Respiratory

Shortness of Breath	No	Yes
Asthma or Wheezing	No	Yes

- Gastrointestinal

Abdominal pain or Heartburn	No	Yes
Peptic Ulcer(stomach or duodenal)	No	Yes

- Genitourinary

Blood in Urine	No	Yes
Kidney Stones	No	Yes

- Musculoskeletal

Joint Pain	No	Yes

- Integumentary (Skin)

Rash or itching	No	Yes

- Neurological

Paralysis	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

- Psychiatric

Memory Loss or Confusion	No	Yes
Depression	No	Yes

- Endocrine

Glandular or Hormone Problem	No	Yes
Thyroid Disease	No	Yes
Diabetes	No	Yes

- Hematologic/Lymphatic

Bleeding or Bruising Tendency	No	Yes
Anemia	No	Yes

- Allergic/Immunologic

History of Skin Reaction or Other Adverse Reaction to:

Penicillin or Other Antibiotics	No	Yes
Morphine, Demerol, or Other Narcotics	No	Yes
Novocaine or Other Anesthetics	No	Yes
Aspirin or Other Pain Remedies	No	Yes
Tetanus antitoxin or Other Serums	No	Yes
Other	No	Yes

List if Other ____________________

____

____

Known Food Allergies ____________________

____

____