



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's Date of Birth: _____

Marital Status: SINGLE DIVORCED MARRIED WIDOWED Sex: M F

Spouse's Name: _____

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

Referred By: _____

Medical Insurance Information (Must Be Completed)

Insured's Name: _____ Relationship to Insured: Self Spouse Dependent

Insured's Date of Birth: _____ Insured's Sex: M F

Person/Guarantor responsible for payment (Must be their LEGAL name):

Vision Plan: _____

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 RESPONSIBILITY: 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. Please 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 _____ - Quality _____
(Where is the pain/problem?) (Example: color of)

- Severity _____ - Duration _____
(How severe is the pain/problem?) (How long have you had this pain/problem?)

- Timing _____ - Context _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem)

- Associated signs/symptoms _____ - Modifying factors _____

(What other associated problems have you been having?)

(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	_____
Glaucoma	NO	YES	NO	YES	_____
Mac Degeneration	NO	YES	NO	YES	_____
Arthritis	NO	YES	NO	YES	_____
Cancer	NO	YES	NO	YES	_____
Diabetes	NO	YES	NO	YES	_____
Heart Disease	NO	YES	NO	YES	_____
Hypertension	NO	YES	NO	YES	_____
Thyroid Disease	NO	YES	NO	YES	_____

PATIENT SOCIAL HISTORY

Birth Order: First Second Third Fourth Five or > Only Twin
 Use of Alcohol: Never Socially Daily Alcohol Dependence
 Use of Tobacco: Never Former Current, packs/day: _____
 Use of Drugs: Never Recreational use Chemical Dependence
 Venereal Disease: No Yes HIV Positive
 Blood Transfusion: No Yes Hepatitis Positive

- 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
 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

- Cardiovascular

Stroke No Yes
 High Blood Pressure No Yes
 High Cholesterol No Yes
 Palpitations No Yes

- Constitutional Symptoms

Good General Health Lately No Yes
 Fever No Yes

- Endocrine

Diabetes No Yes
 Gout No Yes
 Renal Disease No Yes
 Thyroid Disease No Yes

- Gastrointestinal

Acid Reflux No Yes
 Pepcid Ulcer (stomach or duodenal) No Yes
 Colitis No Yes
 Hepatitis No Yes

- Genitourinary

Kidney Stones No Yes
 Ovarian Cysts No Yes
 Prostate Disorder 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
 Novocain 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 _____

- Ears/Nose/Mouth/Throat

Hearing Loss or Ringing No Yes
 Chronic Sinus Problems or Rhinitis No Yes

- Hematologic/Lymphatic

Anemia No Yes
 Breast Cancer No Yes
 Hodgkin's Disease No Yes

- Integumentary (Skin)

Acne No Yes
 Lupus No Yes
 Rash or Itching No Yes

- Musculoskeletal

Joint Pain No Yes

- Neurological

Headache No Yes
 Epilepsy No Yes

- Psychiatric

ADD / ADHD No Yes
 Depression/Anxiety No Yes

- Respiratory

COPD No Yes
 Asthma or Wheezing No Yes