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 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	_____
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

-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 _____

_____

_____

- 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

- 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