CROSSROADS
FAMILY EYECARE

Patient Information

Name: _____ Date:_____

Address:_____ City: _____

Zip:_____ Date of Birth: ___/___/___ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Spouse's Name: _____ Spouse's Date of Birth: ___/___/___

Spouse's Last 4 Digits of SSN: _____ Name of Insurance Policy Holder:_____

Review of Systems (Please Circle All the Apply):

1. *Constitution:* Developmental Disabilities, Cancer, Fatigue Syndrome, Other: _____
2. *Ear/Nose/Throat:* Hearing Loss, Sinus Problems, Dry Mouth, Laryngitis, Other: _____
3. *Neurological:* MS, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraine, Other: _____
4. *Psychiatric:* Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder, Other: _____
5. Cardiovascular: High Blood Pressure (hypertension), Heart Disease, Vascular Disease, Congestive Heart Failure, Heart Attack, Other: _____
6. *Respiratory:* Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea, Other:_____ _____
7. *Gastro Intestinal:* Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other: _____
8. *Genitourinary:* Kidney Disease, Prostate Disease, Prostate Cancer, STP (Herpetic or Chlamydia), Benign Prostate Hypertrophy, Pregnant/Nursing, Other: _____
9. *Muscular/Skeletal:* Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout, Other:_____
10. *Dermatologic:* Eczema, Rosacea, Psoriasis, Herpes Simplex (cold sore), Herpes Zoster (Shingles), Other:_____ _____
11. *Endocrinology:* Type 2 Diabetes, Type 1 Diabetes, Thyroid Dysfunction, Hormonal Dysfunction, Other:_____ _____
12. *Hematological/Lymphatic:* Anemia, Large Volume Blood Loss, Ulcer, High Cholesterol, Other: _____
13. *Allergy/Immunologic:* Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, Other: _____

Medication, Usage, and Dosage (Example: Lisinopril High Blood Pressure 10mg)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list previous ocular conditions: _____

Do you wear glasses?: ___ Yes ___ No Do you wear contacts?: ___ Yes ___ No

Social History: Do you drink alcohol?: ___ Yes ___ No If yes, how often? _____

Do you smoke?: ___ Yes ___ No If yes, how often? _____

Hobbies: _____

Primary Care Physician: _____ Phone: _____

Family Medical History (Please circle all that apply)

Cancer	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Diabetes Type 1	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Diabetes Type 2	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hypertension	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hyperthyroidism	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Hypothyroidism	Father	Mother	Brother	Sister	Son	Daughter	Other: _____

Family Ocular History (Please circle all that apply)

Cataract	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Macular Degenerative	Father	Mother	Brother	Sister	Son	Daughter	Other: _____
Glaucoma	Father	Mother	Brother	Sister	Son	Daughter	Other: _____

How Did you hear about us?

Friend or Family Who? _____ Website Facebook

PROCEDURES MAY BE INDICATED AND DISCUSSED THAT EXCEED THE MINIMUM THAT IS APPROVED BY INSURANCE
(If insured, please check one below)
_____ I DO authorize those services today. I want complete and optimal eye care even if I incur out of pocket costs.
_____ I DO NOT authorize those services today, I do not want extra out of pocket costs, so limit my care to what should be covered.

I authorize and consent to the examination and treatment of the above patient. I certify that the above information is correct. I authorize the doctor to release any information needed to process my insurance claims and I assign payment to the provider of any benefits. I am responsible for fees incurred and any additional cost of collection including reasonable attorney's fees and interest at 2% per month on any unpaid balance on this account and I agree to promptly pay amounts due when incurred or upon insurance denial.

Signature: _____ Date: _____

HIPPA Notice of Privacy Practices

Effective 01/01/2017

I hereby authorize and request the medical treatment necessary for the care of the above-named patient.

I hereby give my consent for Crossroads Family Eyecare to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I allow the electronic transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Crossroads Family Eyecare.

I understand payment is due at the time service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of may charges.

I may revoke my consent in writing except to the extent that Crossroads Family Eyecare has already made disclosures in reliance upon my consent – If I do not sign this consent or later revoke it, Crossroads Family Eyecare may decline to provide treatment to me.

I further authorize and request that insurance payments be made directly to Crossroads Family Eyecare should they elect to receive such payment.

I have received and or read a copy of Crossroads Family Eyecare's Notice of Privacy Practices that tell me my rights and how Crossroads Family Eyecare will use and disclose my protected health information.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

Patient Name: _____

_____ _____

Signature of Patient or Legal Guardian Date