

PATIENT INFORMATION	INSURANCE					
Date	Who is responsible for this account?					
SS/HIC/Patient ID #	I I Polationahin to Patient					
Patient Name	Insurance Co.					
Last Name	I.D.#					
	Is patient covered by additional insurance? ☐ Yes ☐ No					
First Name Middle	Subscriber's Name					
Address	Birth date SS#					
City	Relationship to Patient					
State Zip	Insurance Co					
E-mail	I.D.#					
Sex □ M □ F Age Birth date						
☐ Married ☐ Widowed ☐ Single ☐ Minor	and assign directly to					
☐ Separated ☐ Divorced ☐ Partnered for	and assign directly to years					
Occupation	Dr all insurance benefits if any					
Patient Employer/School	cially responsible for all charges wether or not paid by insurance. I authorize the					
Employer/School Address	use of thy signature of all insurance submissions.					
	close such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining in-					
Employer/School Phone ()_	surance benefits or the benefits payable for related services. This consent will					
Spouse's Name signed below.						
Birth date SS#						
Spouse's Employer Please print name of Patient, Parent, Guardian or Personal Representative						
Whom may we thank for referring you?	Date Relationship to Patient					
	PHONE NUMBERS					
Home () Cell ()	Spouse's Work Phone () Ext					
Best time and place to reach you						
IN CASE OF EMERGENCY, CONTACT (Specify soil						
Name	Relationship					
	Work Phone () Ext					
<u>E</u> `	'E HEALTH HISTORY					
Physician's Name	Place a mark on "Yes" or "No" to indicate if you have had any of the following:					
Date of last visit	Bloodshot Eyes ☐ Yes ☐ No Floaters or Spots ☐ Yes ☐ No Blurred Vision - Distance ☐ Yes ☐ No Glaucoma ☐ Yes ☐ No					
Date of last eye exam	Blurred Vision - Near ☐ Yes ☐ No Headaches ☐ Yes ☐ No					
Name of doctor	Burning Eyes ☐ Yes ☐ No ☐ Itching Eyes ☐ Yes ☐ No ☐ Cataracts ☐ Yes ☐ No ☐ Light Sensitive ☐ Yes ☐ No ☐ No ☐ Yes					
Do you wear glasses? ☐ Yes ☐ No ☐ All the time ☐ Occasionally	Color Vision, Poor ☐ Yes ☐ No Loss of Vision ☐ Yes ☐ No					
☐ Reading ☐ Driving ☐ TV	Crossed Eyes ☐ Yes ☐ No Migraine Headaches ☐ Yes ☐ No Discharge from Eyes ☐ Yes ☐ No Night Vision, Poor ☐ Yes ☐ No					
Do you wear contacts? ☐ Yes ☐ No	Dizzy Spells ☐ Yes ☐ No Red Eyes ☐ Yes ☐ No					
Type Hours/Day	Double Vision □ Yes □ No Seeing Halos □ Yes □ No Dry Eyes □ Yes □ No Seeing Flashes □ Yes □ No					
Describe any problems you have with your	Eye Infection ☐ Yes ☐ No Temporary Loss of Vision ☐ Yes ☐ No					
contacts	Eye Injury ☐ Yes ☐ No Twitching Eyelid ☐ Yes ☐ No Eye Strain ☐ Yes ☐ No Vision Poor ☐ Yes ☐ No					
	Fainting Spells, Blackouts					

		HEALT	H HISTORY			
Physician's Name Date of last visit						
			ny of the following. Also			
relative has had any of	f the following p	oroblems.				
	Yourself	Family Membe	rs		Yourself	Family Members
AIDS/HIV	□ Yes □	No ☐ Yes ☐ No	Hepatitis (Type)	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	□ Yes □	No ☐ Yes ☐ No	High Blood Pressure		☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	□ Yes □	No ☐ Yes ☐ No	Kidney Disease		☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	□ Yes □	No ☐ Yes ☐ No	Lazy Eye		☐ Yes ☐ No	☐ Yes ☐ No
Asthma	□ Yes □	No ☐ Yes ☐ No	Lupus		☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	□ Yes □	No ☐ Yes ☐ No	Migraine Headaches		☐ Yes ☐ No	☐ Yes ☐ No
Blindness	□ Yes □	No ☐ Yes ☐ No	Pacemaker		☐ Yes ☐ No	☐ Yes ☐ No
Cancer	□ Yes □	No ☐ Yes ☐ No	Poor Color Vision		☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	□ Yes □	No ☐ Yes ☐ No	Retinal Disease		☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	□ Yes □	No ☐ Yes ☐ No	Rheumatic Fever		☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	□ Yes □	No ☐ Yes ☐ No	Shingles		☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	□ Yes □	No ☐ Yes ☐ No	Skin Conditions		☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	□ Yes □	No ☐ Yes ☐ No	Stroke		☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	□ Yes □	No ☐ Yes ☐ No	Thyroid Conditions		☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	□ Yes □	No ☐ Yes ☐ No	Tuberculosis		☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	□ Yes □	No ☐ Yes ☐ No	Turned Eye		☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	□ Yes □	No ☐ Yes ☐ No	Are you pregnant?		Number of chi	ldren
Heart Condition	□ Yes □	No ☐ Yes ☐ No	Tobacco Use		Alcohol use	
List any medications you	EDICATION are currently taki		List your allergies		LERGIES lications or othe	r substances:
Pharmacy Name						
Phone ()						
I request that payment of aut			GAP AUTHORIZ Medigap benefits, be made ei	ither to n	ne or on my behalf t	to o me by that provider.
Name of Doc	tor or Clinic			ioi aily s	oci vices iui ilistied (o me by that provider.
			nformation about me to releas termine these benefits or ben			re and Medicaid Ser-
Signature of E	Beneficiary, Guard	an or Personal Representa	ative			Date
Please print name of Beneficiary, Guardian or Personal Representative			Relatio	enship to Beneficiary		

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.

 We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
 - o was not created by us, unless the person that created the information is no longer available to make the amendment,
 - o is not part of the health information kept by or for us,
 - o is not part of the information you would be permitted to inspect or copy, or
 - o is accurate and complete.
- To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person			
Our contact per	rson for all questions, requests or for further info	rmation related to the privacy of yo	our health information is:
		296 Great	Road Acton 1714
Nima	fue Coro & Describles	8/ Baker	Ave Ext. Concold M.
INCEO	Eye Care & Associates	110	Ave Ext. Concoed M. Address
<u>Complaints:</u>			
If you think th	at we have not properly respected the privacy	of your health information, you a	re free to complain to us or to the U.S
Department of	Health and Human Services, Office for Civil Rig	hts. We will not retaliate against yo	u if you make a complaint. If you want to
	send a written complaint to the office contact per	rson at the address, fax or E mail sn	own above. If you prefer, you can discuss
your complaint	in person or by phone.		
Changes to Th	is Notice:		
	right to change our privacy practices and to appl	y the revised practices to health inf	ormation about you that we already have
Any revision to	our privacy practices will be described in a re	vised Notice that will be posted p	rominently in our facility. Copies of this
	available upon request at our reception area.		
	N 0500		
Notice Revised	and Effective: May 2020		
	7		NF 5/2013
	ACKNOWLE	DGEMENT OF RECEIPT	
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	J. 0	C : 0	
I acknowledge	e that I received a copy of Niro Eye	. Care & 1+550017H	, Notice of Privacy Practices.
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		O'constant	
Date	Patient name	Signature	