Rock County EYE CLINIC

PATIENT INFORMATION

Today's Date _____

Name (First, Middle Initial, Last) _____ Date of Birth_____

Preferred name (if other than above) _____ Social Security Number _____

Mailing Address _____

Primary Phone #_____ Alternate Phone #_____

Employer/Job Title _____ Work Phone #_____

Gender: What sex was originally listed on your birth certificate? (circle) Male Female
Gender Identity: (circle) Male Female Transgender _____ Other_____

Race/ Ethnicity: (circle) American Indian/Alaska Native
Asian
African American/Black
Latino / Hispanic/Spanish
Pacific Islander/Hawaiian Native
White
Other

Preferred Language: _____

CIRCLE ALL THAT APPLY

Answer WITH glasses/contacts if you have

Blurred Vision-Distance	Anemia	Lupus
Blurred Vision-Up-Close	Arthritis / Rheumatoid Arthritis	Migraine
Cataracts	Attention Deficit	Multiple Sclerosis
Color Blindness	Cancer	Osteoporosis
Double Vision	Depression / Anxiety / Bipolar	Pregnant (currently)
Dry Eye	Developmental Disability	Respiratory Disease / Asthma
Eye Strain or Headaches	Diabetes	Sjogren's Syndrome
Floater or Spots	Digestive or GI Disease	Sleep Apnea
Glaucoma	Ear, Nose, or Throat Disease	Stroke
Irritation / Pain	Eczema / Psoriasis / Rosacea	Thyroid Disease
Macular Degeneration	Gout	Other (please list) _____
Redness	Heart disease	_____
Retinal Detachment	High Blood Pressure	_____
Wandering or Lazy Eye	High Cholesterol	_____
Watery or Mucus	Kidney Disease	
Eye Injury or Eye Surgery		

Diabetes: _____ Type I _____ Type II When Diagnosed? _____ Treating Physician _____

Last A1C Score & Date_____ Daily Blood Sugar _____ Next diabetic medical visit _____

(SEE NEXT PAGE)

Patient Name_____ **Date of Birth**_____

MEDICATIONS/SUPPLEMENTS (include Over the Counter)	Dosage/Milligrams	How Often
MEDICATION ALLERGIES:		
OTHER ALLERGIES:		

What is your weight? _____ Height? _____

Primary Care Physician/ location: _____

Pharmacy/location: _____

Family Health History (Father/Mother/Siblings/Children)

Y N Cancer Who? _____ Y N Macular Degeneration Who? _____
Y N Diabetes Who? _____ Y N Cataracts Who? _____
Y N High Blood Pressure Who? _____ Y N Glaucoma Who? _____
Y N Thyroid Who? _____

Do you use tobacco products? Y N If YES, How Often do you smoke_____
Prior history of smoking? Y N

Do you consume alcohol products? Y N How often? _____

When was your last eye exam? _____ Where? _____

Do you currently wear contact lenses? Y N What type or brand _____

(SEE NEXT PAGE)

Patient Name_____ **Date of Birth**_____

Contact Lens Prescription Signed Acknowledgement Form

Include below is important information to review prior to receiving your contact lens prescription.

The Centers for Disease Control and Prevention (CDC) makes clear, “Contact lenses can provide many benefits, but they are not risk-free, especially if contact lens wearers don’t practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment.”

The CDC recommends the following for contact lens wearers:

- Schedule a visit with your eye doctor at least once a year.
- Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.
- Understand that eye infections that go untreated can lead to eye damage or even blindness.

The Food and Drug Administration (FDA) indicates:

- “To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It’s safer to be re-checked by your eye care professional.”

Symptoms of Eye Infection include:

- Irritated, red eyes
- Worsening pain in or around the eyes – even after contact lens removal
- Light sensitivity
- Sudden blurry vision
- Unusually watery eyes or discharge

Sign below to acknowledge that you were provided with a copy of your contact lens prescription, at the completion of your contact lens fitting, via access to your PHR (Personal Health Record).

Patient Signature: _____

Date: _____

Patient Name_____ Date of Birth_____

Notice of Privacy Practices

Hawkeye Clinic of Luverne (DBA Rock County Eye Clinic) Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change, and if we change our Notice, you may obtain a revised copy by contacting our office. Hawkeye Clinic of Luverne provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Hawkeye Clinic of Luverne has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Hawkeye Clinic of Luverne reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this consent in writing at any time. However, such a revocation shall not affect any disclosure we have already made in the reliance on your prior Consent.
- Hawkeye Clinic of Luverne may treat conditions upon the execution of this Consent.
- By signing this form you consent our use and disclosure of protected health information about yourself for treatment, payment, or health care operations.

Signature of Patient or Responsible Party _____ Date _____

Signature to File for Insurance

I hereby authorize Hawkeye Clinic of Luverne to submit my insurance claims and that payment of authorized insurance benefits (including Medicare benefits) for any service furnished to me, be made on my behalf to Hawkeye Clinic of Luverne. I understand that I am responsible for any amount not covered by my insurance(s).

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Responsible Party _____ Date _____

Patient Name_____ Date of Birth_____

PATIENT INFORMATION FOR MINORS

Parent / Legal Guardian Information (If Minor)

Father/Legal Guardian Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Cell Phone _____

Employer _____ Work Number _____

Mother/ Legal Guardian Name _____Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Cell Phone _____

Employer _____ Work Number _____