NEW PATIENT INFORMATION

Today's Date ____________________

First Name ______________________________ Last Name ______________________________

Middle Name ______________________________ Nickname ______________________________

Address ______________________________ Date of Birth ______________________________

City/State/Zip ______________________________ Social Security Number ______________________________

Home Phone ______________________________ Work Phone ______________________________

Cell Phone ______________________________

Gender ______________________________ _____ Single _____ Married _____ Widowed

Race: White_____ American Indian or Alaska Native_____ Asian_____ Black or African American_____
Native Hawaiian or Other Pacific Islander_____ Other____________________

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____

Preferred Language: ____________________

PATIENTS Visual Problems with glasses

Y N Distance Vision Blurred
Y N Up-Close Vision Blurred
Y N Double Vision
Y N Wandering or Lazy Eye
Y N Floater or Spots
Y N Eye Strain or Headaches
Y N Watery or Mucus
Y N Redness
Y N Irritation or Pain
Y N Color Blindness
Y N Dry Eye
Y N Cataracts
Y N Glaucoma
Y N Retinal Detachment
Y N Macular Degeneration

PATIENTS Health History

Y N Diabetes
Y N Pregnant
Y N Hypertension
Y N Heart Problems
Y N Stroke
Y N High Cholesterol
Y N Headaches/Migraine
Y N Skin Disease
Y N Thyroid Disease
Y N Ear, Nose, or Throat Disease
Y N Asthma
Y N Respiratory Disease
Y N Arthritis
Y N Osteoporosis
Y N Digestive or GI Disease

Y N Sjogren's Syndrome
Y N Nervous System Disease
Y N Cancer
Y N Kidney Disease
Y N Multiple Sclerosis
Y N Depression
Y N Attention Deficit
Y N Sleep Apnea
Y N Anemia
Y N Rheumatoid Arthritis
Y N Other (please list)_____

____
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____
____

Diabetes: ____ Type I ____ Type II When Diagnosed? ____________ Treating Physician ____________

Your last A1C Score? ________ Daily Blood Sugar ________ Date of last diabetic medical visit ____________

(SEE NEXT PAGE)

Medical Insurance Company? ___________________________

Vision Insurance Plan? ___________________________

List of all medications you are taking:

Name of medication	Dosage/Milligrams	How Often

Or would you like to supply a medication list to be copied? _____ Yes

Are you allergic to any medications? ___________________________

Any other allergies? ___________________________

Medical Health History

What is your weight? __________ Height? __________ Primary Care Physician ___________________________

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

Y N Diabetes Who? ______________

Y N Glaucoma Who? ______________

Y N Cataracts Who? ______________

Y N Macular Degeneration Who? ______________

Y N Thyroid Who? ______________

Y N Cancer Who? ______________

Y N Hypertension 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 ___________________________

Past Eye Surgeries? Y N

Type of Surgery & Date ___________________________ Eye(s) Affected __________

Name of Surgeon: ___________________________

(SEE NEXT PAGE)

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 revocations 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 INFORMATION FOR MINORS

Parent Information (If Minor)

Father's Name ______________________ Date of Birth ______________

Address ____

City ______________ State __________ Zip Code ______________

Social Security Number ______________ Cell Phone ______________

Employer ______________________ Work Number ______________

Mother's Name ______________________ Date of Birth ______________

Address ____

City ______________ State __________ Zip Code ______________

Social Security Number ______________ Cell Phone ______________

Employer ______________________ Work Number ______________