AHRENS
VALLEY EYEWORKS
Where Service, Quality & Integrity meet the eye

New Patient Registration

PATIENT'S INFORMATION *(please print clearly)*				
Last name:	First name:	Middle initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Partner's name *(if married):*	Date of birth:	Gender: ☐ M ☐ F	Last 4 digits of Soc. Security No.:	
Street address:			Home phone:	
City:	State:	Zip:	Work phone:	
Email Address:			Cell Phone:	
Occupation:	Employer's name:		Employer's phone:	
Employer's address:				
Preferred contact: Home Work Cell Email				
Who referred you to us? ☐ Doctor ☐ Website ☐ Advertisement ☐ Insurance Co. ☐ Facebook ☐ Friend/Relative: _____				

INSURANCE INFORMATION *(please show insurance card for patient's record)*			
Person responsible for bill:	Date of birth:	Address *(if different)*:	Contact No.:
Subscriber's name:	Subscriber's Soc. Security No.:	Date of birth:	Insurance ID No.:
Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____			

IN CASE OF EMERGENCY		
Name:	Relationship to patient:	Contact No.:

I understand that, as the patient, I am ultimately responsible for the entire bill whether or not my insurance carrier pays their portion. Eligibility verification is provided only as a courtesy. I authorize full payment to go to Ahrens Valley Eyeworks and all its associates for services rendered. I further authorize release of medical records or other information necessary to process any and all claims on my behalf.
By signing below, I am verifying that the information provided is correct. Additionally, I have been advised of where Ahrens Valley Eyeworks keeps its HIPAA privacy information displayed. If I would like a copy, one will be provided to me upon request.

Signature:	Print Name:	Date:

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Medical History

Name:	Date:
Date of birth:	Do you wear contact lenses: ☐ No ☐ Yes
Last eye exam:	Brand:
Last physical exam:	Average wear time per day:
Name of Primary Care Physician:	Replacement every _____ days / weeks / months

PATIENT OCULAR HISTORY			FAMILY OCULAR HISTORY	
Cataracts	☐ No	☐ Yes	☒ No	☐ Yes (if yes, who _____)
Glaucoma	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Macular Degeneration	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Strabismus (crossed eyes)	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Eye injury or surgery	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Amblyopia (lazy eye)	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Other: _____				

PATIENT MEDICAL HISTORY			FAMILY MEDICAL HISTORY	
Diabetes	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Hypertension	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Heart disease	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
High cholesterol	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Thyroid	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Rheumatoid arthritis	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Auto-immune disorder	☐ No	☐ Yes	☐ No	☐ Yes (if yes, who _____)
Other: _____				

Please list all medications: _____

ALLERGIES			PATIENT SOCIAL HISTORY		
Drug	☐ No	☐ Yes _____	Alcohol	☐ No	☐ Yes
Environmental	☐ No	☐ Yes _____	Tobacco	☐ No	☐ Yes
Over-the-counter meds	☐ No	☐ Yes _____	Drugs	☐ No	☐ Yes
Surgery / Hospitalizations	☐ No	☐ Yes _____	Hobbies / Crafts	☐ No	☐ Yes

REVIEW OF SYSTEMS / HOW YOU ARE FEELING NOW:					
General: Fever, weight loss, weight gain, fatigue	☐ No	☐ Yes	**Skin:** Rashes, itching, dryness, lumps	☐ No	☐ Yes
Ear, Nose, Throat: Tinnitus, stuffiness, sore throat	☐ No	☐ Yes	**Neurologic:** Numbness, dizziness, tremor, seizure	☐ No	☐ Yes
Cardiovascular: Chest pain, palpitations, tightness	☐ No	☐ Yes	**Psychiatric:** Nervousness, anxiety, depression	☐ No	☐ Yes
Respiratory: Cough, shortness of breath, wheezing	☐ No	☐ Yes	**Hematologic:** Easy bleeding, bruising	☐ No	☐ Yes
Gastrointestinal: Heartburn, nausea, vomiting, constipation, diarrhea	☐ No	☐ Yes	**Endocrine:** Excessive thirst, hunger, urination, heat / cold intolerance	☐ No	☐ Yes
Genitourinary: Frequent urination, urgency, bleeding, impotence	☐ No	☐ Yes	**Allergic:** Reaction to foods, environment, drugs	☐ No	☐ Yes
Musculoskeletal: Joint pain, stiffness, instability	☐ No	☐ Yes			

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Our Policies

OTHER USES AND DISCLOSURES

We will not make any uses or disclosures of your health information without your written and signed authorization form. The content of an authorization form is determined by federal law. We may initiate the authorization process if it is your intent for us to share your information with other parties. In this situation, please provide us with a properly completed authorization form. If needed, we can provide the form for you to fill out.

If we initiate the process, we will request that you sign an authorization form, which you can choose to decline, in which case, we cannot make the disclosure. If you do sign the form, you may revoke it at any time in writing unless we have already acted in reliance upon it.

NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by the law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the updated notice, and have copies available in our office.

LATE AND CANCELLATION POLICY

Our goal is to provide quality optical care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call us as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Apppointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

Late Cancellation / No-Shows
A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $50 missed appointment fee.

Patient / Guardian Signature: Date:

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