

**EYEONE
RETINA CARE OF VIRGINIA**

PATIENT INFORMATION (PLEASE PRINT)

REVISED 01/17

(NAME) LAST FIRST MI			DATE OF BIRTH	MARITAL STATUS SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER <input type="checkbox"/>	SEX
STREET ADDRESS		CITY, STATE & ZIP CODE		HOME PHONE #	
MAILING ADDRESS		CITY, STATE & ZIP CODE		CELL PHONE #	
SOCIAL SECURITY #		<input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED	EMPLOYER	PHONE #	
RACE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> KOREAN <input type="checkbox"/> MULTIRACIAL <input type="checkbox"/> OTHER		LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> DEAF <input type="checkbox"/> OTHER		ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> OTHER	
EMAIL			PRIMARY CARE PRACTITIONER		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #
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INSURANCE INFORMATION

CARRIER	ID #
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IF POLICY HOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE

POLICY HOLDER _____	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
SOCIAL SECURITY # _____		
DATE OF BIRTH _____		
EMPLOYER _____		

IF PATIENT IS A MINOR (GUARANTOR INFORMATION)

LAST FIRST MI	DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS, CITY, STATE, & ZIP CODE		HOME PHONE #
EMPLOYER		WORK PHONE #

EyeOne / RetinaCare of Virginia

Patient Name _____ Date of Birth ____ / ____ / ____ Date _____

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Medications (if unable to complete staff will assist you)
 (Attach list or list any medications that you now take.)

<u>Eye Medications</u>	<u>Other Medications</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies NONE

<u>List Allergies</u>	<u>Reaction (Ex: Rash)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Eye History – Have you ever experienced any of these eye conditions? Please circle all that apply.

Cataract _____

Cornea/Conjunctiva problem _____

Glaucoma _____

Refractive Surgery/LASIK _____

Neurological eye problem _____

Plastic Surgery around eyes _____

Retina: Tears Detachment _____

Eye Turning In or Out _____

Medical History
 List any medical conditions for which you have been treated:

Family History Please circle all condition(s) that occur in your family.

	<u>RELATIONSHIP</u>
Blindness	_____
Cataracts	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Disorders	_____
High Blood Pressure	_____
Diabetes	_____
Heart Disease	_____

Surgical History
 List surgery and date of surgery.

Social History
 Are you a:

___ Current every day smoker

___ Current some day smoker

___ Former smoker

___ Smoker, current status unknown

___ Never smoker

___ Unknown if ever smoked

Alcohol use? ___ Yes ___ No ___ Formerly

Blood Sugar (If known)

Blood Sugar _____ A1C _____

Date Taken _____

Tech Review _____ Date _____	Tech Review _____ Date _____
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Additional Insurance Information

Insurance Name _____

Insurance Phone # _____

Member ID # _____

**Name of Vision Coverage
(if known)** _____

Group # _____

Subscriber Name _____

Subscriber SSN _____

Subscriber DOB _____

General Consent for Treatment

The Practice: EyeOne, P.L.C., RetinaCare of Virginia

Patient Name: _____ **DOB:** ____/____/____

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize and direct the practitioners and professional staff to provide medical treatment to me, or the above named patient. I agree to examination, evaluation, treatment, diagnostic tests, procedures, and administration/injection of pharmaceuticals. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct the Practice and my attending practitioner to release such medical and demographic information as necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors. I authorize my employer to release all information regarding employment and salary verification. I authorize my insurance company to release all information regarding my benefits.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT: I hereby authorize and direct my insurance carrier and/or health care plan to make payment to the Practice and hereby assign to the Practice any and all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by the Practice. I acknowledge that it is my responsibility to notify the Practice of change in healthcare benefits or to obtain pre-certification for services. I understand that I am financially responsible to the Practice for all charges (regardless of insurance determination) including court cost, judgment cost, 25% collection costs, reasonable attorney fees, interest on past due balances, return checks, return check fees, and those charges not paid by insurers or health care plans incurred by me or in my behalf or the above named person. I understand I will receive a separate bill from my attending practitioner, emergency department, radiologist, anesthesiologist and hospital. Missed or cancelled appointments without 24 hour prior notification may be charged a missed appointment fee.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our privacy practices. I acknowledge that such Notice of Privacy Practices is displayed in the office or is available at www.eyevoneva.com or will be provided to me in print, upon requested and it is my responsibility to read this Privacy Notice if I desire. The Practice reserves the right to change our privacy practices as deemed necessary and our responsibility to publish the changes accordingly.

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) brought into the office or hospital is my responsibility and the Practice shall not be liable for loss or damage to any personal property.

CONFIDENTIAL TESTING: I understand that I have a responsibility to keep myself and others safe from HIV infection and other diseases therefore I consent to confidential testing as ordered by the Medical Director. I understand that the results will be documented in my medical chart. As long as this consent is in force the practice may require me to submit to tests without asking me to sign another consent form.

RIGHT TO REVOKE: My consent shall remain in effect until revoked in writing. I understand that I have the right to revoke this General Consent for Treatment by providing written notice to EyeOne, P.L.C, 17 North Medical Park Drive, Fishersville, VA 22939 Attention: Practice Manager. It is understood that treatment will be denied if this General Consent for Treatment is not signed or revoked.

Print Patient Name: _____ **Date:** _____

Signature _____
(Patient of person authorized to consent or as Guardian/Guarantor)