EYEONE

RETINA CARE OF VIRGINIA

PATIENT INFORMATION (PLEASE PRINT) **REVISED 01/14**

(NAME) LAST FIRST MI	DATE OF BIRTH	MARITAL STATUS SINGLE ☐ WIDOWED ☐ MARRIED ☐ OTHER ☐	SEX

STREET ADDRESS	CITY, STATE & ZIP CODE	HOME PHONE #
MAILING ADDRESS	CITY, STATE & ZIP CODE	CELL PHONE #

SOCIAL SECURITY #	☐ DISABLED ☐ RETIRED	EMPLOYER PHONE #

RACE	LANGUAGE	ETHNICITY
☐ AFRICAN AMERICAN	☐ ENGLISH	
☐ CAUCASIAN	☐ SPANISH	☐ HISPANIC OR LATINO
☐ HISPANIC	☐ MUTE/DEAF	☐ NOT HISPANIC OR LATINO
☐ KOREAN	☐ OTHER	☐ OTHER
☐ MULTIRACIAL		
☐ OTHER		

EMAIL	PRIMARY CARE PRACTITIONER

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #

INSURANCE INFORMATION

CARRIER	ID #

IF POLICY HOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE

POLICY HOLDER ____ MALE ☐ FEMALE ☐

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 ________

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

Eye Medications	Other Medications
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Allergies ☐ NONE

List Allergies	Reaction (Ex: Rash)
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________

Medical History

List any medical conditions for which you have been treated:

____
____
____
____
____
____
____
____
____
____
____

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

Surgical History

List surgery and date of surgery.

____
____
____

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

	RELATIONSHIP
Blindness	__________________
Cataracts	__________________
Glaucoma	__________________
Macular Degeneration	__________________
Retinal Disorders	__________________
High Blood Pressure	__________________
Diabetes	__________________
Heart Disease	__________________

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_______

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.eyeoneva.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)