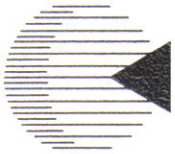
PLEASE PRINT CLEARLY



PHILADELPHIA EYE
ASSOCIATES

PATIENT REGISTRATION

Gender □**Male** □**Female** **Social Security Number:**_____

Name:_____ **Birth date**_____
Last First Middle Initial mm/dd/yyyy

Home address:_____ **Apt#**_____

City:_____ **State:**_____ **Zip Code**_____

Home phone#_____**Work phone#**_____**Ext.**_____**Cell phone**_____

E-mail address:_____@_____._____

In case of Emergency contact:_____ **Relationship:**_____

Telephone #_____

Primary Care Doctor:

Primary Doctor:_____

Address:_____

City:_____ **State:**_____ **Zip Code**_____

Telephone #_____**Fax#**_____

Were you referred to us by your Primary Doctor? □Yes □ No If not, how did you hear about Philadelphia Eye Associates: □ Advertisement □ Insurance □ Web site □ Family/Friend

□ Other:_____

Permission to discuss Medical care: I hereby give PEA permission to discuss and answer any questions regarding my medical care/condition to: (This must include translators)

Name:_____**Relationship:**_____

Telephone #_____

PLEASE PRINT CLEARLY

Primary Medical Insurance Information:

Name of Primary Medical Insurance Policy (Not your vision coverage):

_____

Insurance ID #_____Group #_____

Primary Policy Holder's Name_____Date of Birth_____

Your relationship to primary: □ Self □ Spouse □ Child □ Other:_____

Does Primary insured have the same address as the patient? □ Yes □ No

If not: Address of policy holder:_____

City:_____State_____Zip code:_____

Home phone:_____Work phone:_____Ext._____

Secondary Insurance and/or Vision plan:

Name of secondary insurance policy:_____

Insurance ID#_____Group#_____

Name of vision care policy:_____

Vision care ID#_____Group#_____

Guarantor information for Secondary Insurance/Vision plan:

Name of Policy holder:_____ Date of Birth_____

Your relationship to primary: □ Self □ Spouse □ Child □ Other:_____

Does Primary insured have the same address as the patient? □ Yes □ No

If not: Address of policy holder:_____

City:_____State_____Zip code:_____

Home phone:_____Work phone:_____Ext._____

Assignment of Benefits & Confidentiality:

Assignment of Insurance benefits: I hereby authorize direct payments to PEA for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

Authorization to release information: I hereby authorize PEA to release any medical or incidental information that may be required for either medical care or in processing application for financial benefit.

Medicare-Medicaid: I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Consent to photograph: I hereby authorize the doctors of PEA to photograph, televise or videotape or permit others to do so while under his/her care. Photographs will be used mainly for documentation of medical or surgical progress, and may be used for teaching, publication or research. My name will not be used.

Protected Health Information:

Philadelphia Eye Associates' (PEA) 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 this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You also have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

- **My protected health information may be disclosed or used for treatment, payment or health care operations.**
- **I have the right to review PEA's "Notice of Privacy Practices".**
- **PEA has the right to change their policies.**
- **I have the right to restrict the use of my information but PEA does not have to agree to those restrictions.**
- **I may revoke this consent in writing at any time and all future disclosures will then cease.**
- **PEA may condition treatment upon the execution of this consent.**

Identity Theft Protection:

Patients must provide photo ID along with their current health insurance cards. If the patient is a minor, the parent or guardian should bring their photo ID. This photo will be kept in the patient's chart at all times and will be used to identify the patient at each visit.

_____

Signature of Patient or representative

_____

Relationship if other than patient

Date:_____

PHILADELPHIA EYE ASSOCIATES

Name:_____ **D.O.B**_____
(Last) (Middle) (First)

PAST OCULAR HISTORY: **First visit date**:_____ **Gender** ☐ Male ☐ Female

Eye Diseases: ☐ None

☐Glaucoma date_____
☐Ocular Hypertension date_____
☐Diabetic Retinopathy date_____
☐Cataracts date_____
☐Dry Eye Syndrome date_____
☐Other:
_____ date_____
_____ date_____
_____ date_____

Eye Surgery ☐ None

_____date_____
_____date_____
_____date_____
_____date_____
_____date_____
_____date_____

Eye Surgery (continued)

_____date_____
_____date_____
_____date_____
_____date_____
_____date_____
_____date_____

Family History of Eye Disease: ☐ None
☐ Glau ☐ Cat ☐ Mac Degen ☐ Other:_____

Family History of Medical: ☐ None
☐ Diabetes ☐Hypertension ☐ Other:_____
☐ Heart Condition

PAST MEDICAL HISTORY:

List of **Medications** you are using:☐ None

Start & Discontinued Dates

_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
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_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____
_____Start_____DC_____

Drug Allergies: ☐ none ☐ yes (please list)

_____
_____

Medical Illnesses (List an illness for each of your medicines & surgeries)

Date diagnosed (mm/yr)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgery: ☐ none ☐ yes (please list) ***Dates (mm/yr)***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS: Use this system as a guide to obtain history for above areas

- ●None (New patient only Visit Date_____)
- ●Skin
- ●Head, Ears, Nose, Throat
- ●Lungs, Breathing, Heart, Blood vessels
- ● Digestive system, Kidney, genitals
- ● Bones, joints, muscles
- ● Neurologic or Psychiatric
- ● Cancer
- ● Exposure to Infectious Diseases
- ● Endocrine System

SOCIAL HISTORY

●Occupation:_____
Smoke: ☐ Yes ☐ No D/C date_____
Drink: ☐ Yes ☐ No D/C date_____
Drive: ☐ Yes ☐ No D/C date_____
Use a computer: ☐ Yes ☐ No