Shoreline Eye Associates, P.C.
515 Boston Street
Guilford, CT 06437
PH: (203) 453-3100
Fax: (203) 458-9456

Patient Registration

Please review, make any necessary changes and supply any missing information

Patient Name				**Salutation**	
Date of Birth		**Age**		**Sex**	
Address			**SS#**		

Communication					
Preference		**Cell Phone #**			
Home Phone #		**Work Phone #**		**Ext.**	
Email					

Would you like to receive electronic summaries of your visits?
You will be required to set up an account and password through our patient portal. _____Yes _____No

Information			
Marital Status		**Primary Language**	
Race		**Ethnicity**	Not Hispanic or Latino
Primary Dr.		**Occupation**	

Account Responsible					
Name				**Salutation**	
Relationship		**SS #**			
Address					
Home Phone #		**Work Phone #**		**Ext.**	
Primary Insurance					
Name		**Group Name**			
ID #		**Group #**			
Address					
Insured		**Insured Date of Birth**			
Secondary Insurance					
Name		**Group Name**			
ID #		**Group #**			
Address					
Insured		**Insured Date of Birth**			

Do You have VSP (Vision Service Plan) for exam, glasses or contact lenses? _____Yes _____No

Emergency Contact					
First and Last Name				**Relationship**	
Home Phone #		**Cell Phone#**		**Work Phone#**	

I HAVE READ AND UNDERSTAND MY RIGHTS AS OUTLINED IN THE HIPAA COMPLIANCE ACT.
I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts medicare assignment.

SIGNATURE_____ **DATE**_____

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New Patient Health History

In order to provide the highest quality of care possible, it is important that we have the following information. Please answer the questions as accurately as possible. If you do not understand the questions, please ask for assistance.

Thank you

PATIENT NAME_____ **Date of Birth**_____

Primary Care Physician		**Referred by**	

Your Past / Present Eye History

What is the chief reason for your visit today?

Please check Yes or No if you HAVE or HAD the following:			
Glaucoma	___No ___Yes	**Dry Eye**	___No ___Yes
Cataracts	___No ___Yes	**Strabismus (Eye Turn)**	___No ___Yes
Macular Degeneration	___No ___Yes	**Amblyopia (Lazy Eye)**	___No ___Yes
Retina Disease	___No ___Yes	**Blindness**	___No ___Yes
Diabetic Eye Disease	___No ___Yes	**Eye Injury**	___No ___Yes
Corneal Disease	___No ___Yes	**Other**	___No ___Yes
Do you wear Glasses?	___No ___Yes		

Do you wear Contact Lenses?	___No ___Yes : **Type:** Soft / Hard / Gas Permeable / Daily Wear / Extended Wear **Replacement Schedule:** Daily / Weekly / Monthly / Yearly **Hours worn today:**_____ **Average hours worn a day:**_____
Have you ever had Eye Surgery?	___No ___Yes : **Describe:** **Surgeon:**
Do you use any Eye medications?	___No ___Yes : **Please List:**

Your Medical History

Please check yes or no if you have the following:			
Diabetes	___No ___Yes	**Cancer**	___No ___Yes
High Blood Pressure	___No ___Yes	**Arthritis**	___No ___Yes
High Cholesterol	___No ___Yes	**Hay Fever**	___No ___Yes
Heart Problem	___No ___Yes	**Bleeding Problem**	___No ___Yes
Stroke	___No ___Yes	**Migraine**	___No ___Yes
Asthma	___No ___Yes	**Dementia**	___No ___Yes
Emphysema	___No ___Yes	**Men: Prostate Problem**	___No ___Yes
Thyroid Problem	___No ___Yes	**Women: Pregnant now**	___No ___Yes

Please list any other illnesses or health information:

Your Social History		
Do you drink alcohol?	____No ____Yes:	Occasional / Social / 1 a day / More than 1 a day
Do you smoke?	____No ____Yes	Please circle one: Never a smoker / Former Smoker
Please list any hobbies:		

Family History			
Please list any family members with these conditions:			
Glaucoma		**Diabetes**	
Cataracts		**Cancer**	
Macular Degeneration		**Heart Disease**	
Retina Disease		**Hypertension**	
Blindness		**High Cholesterol**	
Strabismus/ Lazy Eye/ Amblyopia		**Kidney Disease**	
Other Eye Disease		**Other**	

Your Medications		
Please list any medications that you are currently taking: (use the back of the form if you need more room)		
Name	**Strength**	**Directions**

Your Allergies
Please list any drug allergies:

Medical Alerts
Please list all medical alerts (i.e., Epilepsy, DNR / DNI)

PATIENT SIGNATURE_____ **DATE**_____

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Acknowledgment Of Privacy Practices

_____
Date

I, _____, acknowledge that I have received a copy of the
(print patient name)
Notice of Privacy Practices from Shoreline Eye Associates, P.C.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received this organizations *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address named above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information:

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Acknowledgment of Privacy Practices, but was unable to do so as documented below:

Date	Initials	Reason