Scarbrough Family Eyecare
527 West Front Street Traverse City, Michigan 49684
(231) 947-8667
www.ScarbroughFamilyEyecare.com

Scarbrough Family Eyecare
HEALTH | VISION | COMPASSION | TECHNOLOGY

Patient Registration

Date:_____

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

Patient Name:		**Nickname:**
Date of Birth:	**Age:**	**Marital Status:**
Sex:		**SS #**
Mailing Address: **City:** **State:** **Zip Code:**		
Communication		
Home Phone #	**Work Phone #**	**Extension:**
Cell Phone #		
EMAIL: **Your email address is used to send the results of your exam to you and for recall purposes. ____**		
Information		
Primary Language (check one): English _____ Spanish _____ French _____ Other _____ Decline to specify _____	**Race (check one):** American Indian ____ Asian ____ Black or African American ____ Pacific Islander ____ White ____ Decline to specify ____	**Ethnicity (check one):** Not Hispanic or Latino __ Hispanic or Latino __ Decline to specify __
Occupation:	**Employer:**	
Account Responsible		
Responsible:		
Relationship:		**SS #**
Mailing Address: **City:** **State:** **Zip Code:**		
Cell Phone #	**Work Phone #**	**Extension:**

Emergency Contact					
First:	**Last:**	**Relation:**	**Home #**	**Cell #**	**Work #**

NEW PATIENTS ONLY - How did you hear about us?

Friend/Family(Name):_____ Traverse Magazine ____Google Reviews____

Facebook ____ Website____ Insurance____Other_____*Ask an employee about our $10 Referral Program*

Patient Health History

Please review, make necessary changes and supply any missing information. Date:

Patient Name:		**Date of Birth:**
Primary Care Physician:	**Reason for Last Visit:**	**Approximately when was your last visit:**
<u>New Patients only:</u> **Last Eye Doctor:**		**<u>New Patients only:</u>** **Date of last eye exam:** **Dilated: Yes___ No___**

Medical History			
Please list any *CURRENT* illnesses, symptoms or problems:			
Heart / Blood Pressure		**Nerves / Brain**	
Ears, Nose, Throat		**Psychiatric**	
Breathing		**Kidneys / Thyroid**	
Stomach		**Blood**	
Urinary / Reproductive		**Allergies (not medications)**	
Bones / Joints / Muscles		**Diabetes**	
Skin		**Headaches**	
Other			

Do you work on a computer?	**Hours per day:**

Diabetic Information
Blood Sugar test: Value/Reading:_____ A1c test : Value/Reading:_____

Eye Surgery Information	
Procedure:	**Eye:**

Past / Present Eye History		
Please list any past or present EYE illnesses, symptoms or problems:		
	Self:	**Family:**
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Lazy Eye		
Diabetes		
Dry Eye		
Refractive		

Social History
Are you a smoker, former smoker or never smoked? _____ **Do you smoke everyday or some days? _____**
Occupation:

Lifestyle Information:
Please circle any of the following that pertain to you: Drive a lot at night. Work Outside in the Sun. Hazardous Job; construction, etc. Walking; Running; Biking, Read for work/Pleasure, Shooting Sports; hunting, etc. Water Sports; fishing, etc. Team Sports; baseball etc. Other special vision needs: _____

Current Medications
(OR WE CAN COPY YOUR MEDICATION LIST)

Please cross out any medications that you are no longer taking
Please list all prescriptions, over the counter and herbal medications

Date	Name	Strength	Directions

Are you allergic to any medications? If yes, please list:			

Contact Lens History					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, weekly, 2 weeks, monthly, extended)	

Pupil Dilation:
To perform a comprehensive eye examination it may be necessary for the doctor to dilate your pupils with eye drops. The side effects of pupil dilation can last for several hours and include: sunlight sensitivity and possible blurred vision. Some patients prefer to have someone drive them home following pupil dilation. If found necessary, I prefer to be dilated: ____ Today ____ Some other day ____ Prefer not to be dilated

Scarbrough Family Eyecare
Scarbrough Professional Services, P.C.
527 West Front Street
Traverse City, Michigan 49684
(231) 947-8667
www.ScarbroughFamilyEyecare.com

Acknowledgement Of Privacy Practices

I agree to the use and disclosure of my protected health information by Scarbrough Family Eyecare for the purpose of diagnosing, providing treatment to me, or obtaining payment for my health care bills and to conduct health care operations of Scarbrough Family Eyecare.

I request that payment of my insurance benefits or Medicare be made either to me or on my behalf to Scarbrough Family Eyecare for any services rendered to me.

I will allow you to file directly to my insurance carrier(s) for me, and I accept responsibility for obtaining necessary insurance forms if my insurance company requires its own form.

I understand I am financially responsible for any amount not covered by my insurance contracts or Medicare. This includes deductible, co-pays, and non-covered services.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

I have the right to revoke this consent, in writing, at any time, unless they have already treated me, sought payment for their services, or performed health care operations in reliance upon their ability to use or disclose my health information in accordance with this consent. I understand that this office can decline to serve me if I choose not to sign this form.

Scarbrough Family Eyecare's Notice of Privacy Practices describes your rights and the duties of this office with respect to your protected health information. Please refer to this notice posted in the lobby or ask for a copy.

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices from Scarbrough Family Eyecare.

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 _____

Emergency Contact					
First:	**Last:**	**Relation:**	**Home #**	**Cell #**	**Work #**

Revised: 1/1/2018