

PATIENT NAME _____ **DATE OF BIRTH** _____ **AGE** _____ **FEMALE**[] **MALE**[]

If Patient Is a Minor, Please Name Responsible Party

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____

Occupation _____ **Business Phone #** _____

Patient's Employer _____ **Full-Time Student?** Y [] N []

Patient's Marital Status _____ **Patient's Social Security Number (Optional)** _____ - _____ - _____

Spouse's Name _____ **Phone #** _____

Emergency Contact Name _____ **Phone #** _____

Primary Care Physician _____ **Phone #** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? [] **INSURANCE PLAN** [] **PHONE BOOK** [] **WEBSITE** [] **FAMILY OR FRIEND**
[] **Referred by Dr.** _____ **Phone #** _____

Address _____

INSURANCE INFORMATION

Primary Insurance Name _____ **Are you the Primary Insurance Holder?** Y or N

Name of Insured (If not self) _____ **Insurance Holder's Birth date** ___/___/___ (Required)

Secondary Insurance Name _____

Name of Insured (If not self): _____ **Insurance Holder's Birth date** ___/___/___

AUTHORIZATION AND ASSIGNMENT (Please read and INITIAL after EVERY statement, then SIGN at the bottom.)

I understand that I am responsible for all fees and finance charges for the above patient, regardless of insurance coverage. _____ (Initial)

I hereby authorize Dr Frank to furnish information to insurance carriers concerning my physical condition and treatments, and I assign to Dr Frank all payments for medical services rendered to me or my dependents. _____ (Initial)

I acknowledge that if I do not have the appropriate referrals and authorizations as required by my insurance company or if I do not have my insurance card, I am electing to be treated and agree to pay for services rendered. _____ (Initial)

If, after default, this account is placed in the hands of an attorney for collection, the undersigned agrees to pay 30% of the unpaid balance as the attorney's fee, together with additional costs of collection to the extent permitted by law. _____ (Initial)

This applies to this date and future dates where the referral and/or insurance card is needed and not presented. Lawrence S. Frank M.D. and staff are not responsible to obtain any referrals not presented at the time of visit.

Signature _____ **Date** _____

HEALTH INFORMATION

Thank you for choosing us to provide you with eye care. As part of your eye care and to ensure the greater health benefits, we need information about your health or any changes in your health that have occurred.

1. Please list your prescription medications: (Or give us a list of your medications)

2. Please list non-prescription medications used recently:

3. Are you allergic to any medications? YES NO LATEX gloves? YES NO Other allergies? YES NO

If YES, please list: _____

4. Please list all major surgeries and dates (approximate):

YOUR HEALTH HISTORY

Please Circle YES or NO and Circle specific problem if YES.

- YES NO Diabetes
- YES NO Thyroid Condition
- YES NO Heart Problem
- YES NO High Blood Pressure
- YES NO High Cholesterol
- YES NO Cancer, Leukemia
- YES NO Asthma, Bronchitis, Emphysema
- YES NO Difficulty Breathing, Chest Pain
- YES NO Persistent Cough, Bloody Sputum
- YES NO Stomach, Liver, Intestinal Problems
- YES NO Prostate, Ovarian, or Uterus Problems
- YES NO Hearing, Taste, or Smell Problems
- YES NO Arthritis, Lupus
- YES NO Multiple Sclerosis
- YES NO Seasonal Allergies
- YES NO Headaches
- YES NO Dizziness
- YES NO Night Sweats
- YES NO Smoke, Drink Alcohol (more than 1/day)
- YES NO Weight Loss, Poor Appetite
- YES NO Fever

Other medical problems (please list) _____

FAMILY HISTORY

Circle Yes or No.

- YES NO Diabetes
- YES NO Heart Disease
- YES NO Cancer
- YES NO Cataracts
- YES NO Glaucoma
- YES NO Macular Degeneration

OTHER _____

Do you wear Glasses? YES NO
Do you wear Contacts? YES NO
Have you had LASIK? YES NO
If so, when? _____

Print Name _____

(Please sign or initial every year) Patient Signature _____ **Date** _____

Lawrence S. Frank, MD
Seema A. Gupta, MD

Updated _____ **Date** _____
Updated _____ **Date** _____
Updated _____ **Date** _____

Lawrence S. Frank, MD / Seema A. Gupta, MD
Ophthalmologists, Eye Physicians and Surgeons

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected 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 have received, read and understand your 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 Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private 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 operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Signature: _____

Parent/Guardian Signature If a Minor: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient=s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____