WA Valley Eye and Laser Center

Patient Information Form

Patient Information				
Last Name	First Name		MI	Previous Name (if applicable)
Mailing Address			Apt. #	
City/State/Zip			Social Security # (last 4 digits)	
Home Phone	Cell Phone		Work Phone	
Preferred Method of Contact ☐ Home ☐ Cell ☐ Work	Email Address			
Marital Status	Date of Birth		Gender ☐ Male ☐ Female ☐ Other	
Employer Name			Employer Phone #	
Family Physician or Pediatrician			Family Physician or Pediatrician Phone #	
Emergency Contact Name	Emergency Contact Phone #		Relationship to Patient	
Insurance Information				
Primary Medical Insurance			Secondary Medical Insurance	
Insurance Co. Name			Insurance Co. Name	
Subscriber's I.D. Number			Subscriber's I.D. Number	
Group Number			Group Number	
Policy Holder Name			Policy Holder Name	
Policy Holder's Date of Birth			Policy Holder's Social Security # (last 4 digits)	
Policy Holder's Social Security # (last 4 digits)			Policy Holder's Social Security #	
Patient Relationship to Policy Holder			Patient Relationship to Policy Holder	
Responsible Party (If patient is under the age of 18), the parent or guardian bringing the patient in will be listed as the guardian				
Last Name			First Name	
Date of Birth	Social Security # (last 4 digits)		Phone	
Address of Person Responsible				
City/State/Zip			Relationship to Patient	
Additional Information				
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline to answer			Ethnicity (please select one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer	
Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Sign Language ☐ Other				
Preferred Pharmacy Name & Location:				

I certify that I have read and agree to WA Valley Eye & Laser Center payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of Insurance coverage. I hereby assign to WVELC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $35 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communication from WVELC by text or email at the number of address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made to WVELC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of WVELC Privacy Notice. ☐ (initials)

Signature of Responsible Party: X_____ Date_____

Printer Name of Responsible Party: X_____ Date_____

Washington Valley Eye and Laser Center
Health Questionaire

Patient Name: _____ **Date of Birth:** _____

What is the reason for your visit today? _____
Are you allergic to or sensitive to any medications? No _____ Yes _____
If yes, please list and explain: _____
List any medications you currently take (including eye drops, oral contraceptives, aspirin, over the counter medications and home remedies): _____
_____
_____
List any of the following you have had: Crossed eyes, lazy eye(s), drooping eye lids, prominent eyes, glaucoma, retinal diseases, cataracts, eye infection(s) or eye injury: _____

SOCIAL HISTORY
Do you currently use:
Tobacco? No _____ Yes _____ If no, have you ever? _____ If yes, amount and how long: _____
Alcohol? No _____ Yes _____ Occasionally _____
Recreational & Illegal Drugs? No _____ Yes _____ If yes, what type and how long: _____

REVIEW OF SYSTEMS
Do you currently have or have you ever had any problems in the following areas:

RESPIRATORY	**No**	**Yes**
Asthma	_____	_____
Chronic bronchitis	_____	_____
COPD	_____	_____
NEUROLOGICAL		
Headaches	_____	_____
Migraines	_____	_____
Seizures	_____	_____
VASCULAR/CARDIO		
Heart disease	_____	_____
High blood pressure	_____	_____
High cholesterol	_____	_____
ENDOCRINE		
Thyroid	_____	_____
Diabetes	_____	_____
ALLERGIES		
Allergies/hay fever	_____	_____
Anaphylaxiz	_____	_____
MUSCULOSKELATAL		
Arthritis	_____	_____
Rheumatoid arthritis	_____	_____
IMMUNE SYSTEM	_____	_____
Cancer	_____	_____

Patient signature: _____
Date: _____

HIPAA

Authorization to Receive/Release Health Information

Patient Name: _____

Do you have a person or family member that you authorize to receive and discuss information regarding your personal health information (general, surgical and billing)?

□ **No** □ **Yes**, if yes please provide:

Name: _____ **Relationship:** _____

Phone Number: _____

We keep a record of the health services we provide you. You may request to view and copy your health record; we may charge you a fee to copy those records. Our Notice of Privacy Practices describes in detail how your health information may be used, disclosed and how you can access your information. You may request a complete copy of our Notice of Privacy Practices from our reception desk.

By signing below, I acknowledge the Notice of Privacy Practices summary.

_____ _____

Patient or Legally Authorized Individual **Date**