FAMILY FIRST VISION CARE
PATIENT REGISTRATION AND HISTORY FORM

Full Legal Name _____ Middle Initial _____ Nickname_____ ☐ Single ☐ Married

Street Address _____ City _____ State _____

Zip Code _____ Home Phone ( ) _____ Mobile Phone ( ) _____

Employer's Name _____ Work Phone Number ( ) _____

Email_____

Date of Birth _____/_____/_____ Age _____ SS Number_____ Race _____ ☐ Male ☐ Female

Emergency Contact _____ Relationship _____Phone Number ( ) _____

Is there anything we can do to make this visit better for you?

How would you prefer to be contacted? (Check all that apply) ☐ Email ☐ Text ☐ Mail ☐ Phone

Vision Insurance_____ Medical Insurance_____

Primary's Name _____ D. O. B. _____ SSN_____ Employer_____

Relation to Patient _____ Address (if different) _____

Please answer the following questions about your medical status and history.

1. Have you ever been treated for any medical conditions? ☐ Yes ☐ No **If YES, please explain**
_____

2. Have you ever had any surgery? ☐ Yes ☐ No **If YES, please explain**
_____

3. Have you ever had any eye disease or eye surgery? ☐ Yes ☐ No **If YES, please explain**
_____

4. Do you take any medications? ☐ Yes ☐ No **If YES, please explain**
_____

5. Do you have any drug or food allergies? ☐ Yes ☐ No **If YES, please explain**
_____

6. Family History, Social History and Review of Systems:	**Yes/No**	**If YES, Please explain**
Do you have any of the following problems:		
Chronic fever, fatigue, unexplained weight loss or gain	☐ ☐	_____
Ear / nose / throat problems	☐ ☐	_____
Heart or vascular problems	☐ ☐	_____
Respiratory problems	☐ ☐	_____
Urinary problems	☐ ☐	_____
Skin problems	☐ ☐	_____
Musculoskeletal problems	☐ ☐	_____
Neurological problems	☐ ☐	_____
Psychiatric problems	☐ ☐	_____
Do any medical or eye diseases run in your family	☐ ☐	_____
7. Do you use any tobacco products	☐ ☐	_____
8. Do you drink alcohol?	☐ ☐	_____

9.Have you been exposed to or infected by ☐ HIV ☐ Hepatitis ☐ Gonorrhea ☐ Syphilis ☐ none of the previous

Reviewed by _____ _____
Optometric Physician Date Stamp

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

Office of Dr. Family First Vision Care

2. Persons/organizations authorized to receive the information: Pearle Vision.

3. Specific description of information that may be used/disclosed: My name, address, telephone number, email address and next appointment date(s) and time(s).

4. **As part of our recall program, the information might be used/disclosed for the following purposes:**
   a) For the purpose of providing Pearle Vision coupons and service and product information either from this office or directly from Pearle Vision; and
   b) To compare contact lists with Pearle Vision to help avoid duplicate contacts related to eye exam scheduling within similar time frames.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment: or eligibility for benefits unless allowed by law.

6. The organization authorized to use/disclose the information will receive compensation for doing so. Yes____ No__X

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that: a) action has been taken in reliance on this authorization; or
   b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

9. This authorization expires four years from the date of my signature.

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. The Notice of Privacy Practices that has been made available to you describes these uses and disclosures in detail. You are free to view this Notice at any time before you sign this form.

I have read the Notice of Privacy Policies and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations. I acknowledge that I have received the Notice of Privacy Practices from Family First Vision Care.

X_____ _____

Signature Required **Date**

If signing a legal personal representative of the patient, describe the relationship to the patient and the source of the authority to sign this form

_____ _____

Relationship to patient **Print Name**

If you would like a copy of the HIPPA Privacy Act, Check here ☐ GIVEN _____
Tech Initials

By signing this document, you acknowledge that you have read it in its entirety and agree.