PATIENT INFORMATION **UNITED EYE CENTERS, P.C.**

Legal Name_____ Nickname_____
First M.I. Last

Address_____Bldg #_____Apt #_____

City_____State_____Zip_____

Home Phone(____)_____Work Ph(____)_____Cell Ph(____)_____

Social Security #_____-_____-_____Date of Birth___/___/___Age___Male/Female

Circle One: Single/Married/Widowed/Divorced **Email:**_____

Employer_____Occupation_____

Emergency Contact_____Emerg Phone(____)_____

Primary Care Physician_____Office Phone(____)_____

How did you hear about us/whom may we thank for referring you?_____

INSURANCE INFORMATION
We'll copy your insurance card. Please provide the following information:

Primary Insurance Company_____

Policyholder is: Self / Spouse / Parent / Other **(If other than self please continue)**

Name of Policy Holder_____ID#/SS#_____

Date of Birth___/___/___ Policyholder's Employer_____

Secondary Insurance Company_____

Policyholder is: Self / Spouse / Parent / Other **(If other than self please continue)**

Name of Policy Holder_____ID#/SS#_____

Date of Birth___/___/___ Policyholder's Employer_____

AUTHORIZATION
I have insurance coverage with the above named insurance company and assign payment directly to United Eye Centers, P.C. for all surgical, medical, and routine benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand I am ultimately responsible for all fees, whether paid by insurance or not. I understand that if my insurance carrier requires a co-pay or if I am paying privately for services, it is due at the time services are rendered. I agree with this authorization:

Signed_____Today's Date___/___/___
(By patient or guardian if under 18 years of age)

Patients Name:_____

Pharmacy Name:_____

Cross Street of Pharmacy: _____

When was your last flu shot:_____

Do you currently have any health complaints: Yes / No If yes list ALL:
Prior Surgeries:

Medications:	What is Medication For?:

What are you allergic to?

Common allergies-circle all that apply OR LIST:

Penicillin Codine Sulfa Erythromicin

Others:

Vital Sign/Info:

Height:_____ft_____in

Weight:_____lbs

Last Blood Pressure:

_____/_____

Family History: Mom/Dad/Brother/Sister/Aunt/Uncle/Cousin

Cataracts:	Y / N	Who?
Glaucoma:	Y / N	Who?
Macular Degereration:	Y / N	Who?
Retinal Detachment:	Y / N	Who?
Diabetic Eye Disease:	Y / N	Who?

Social History:

Smoking: Circle ONE

Daily Never Former Smoker

How many:_____/day

# of years:_____ When did you Quit:_____

Alcohol: Circle ONE

Daily Occasionally Never

Type:_____

How many:_____

Rec Drugs: List any

Preferred Language: _____

Preferred Method of contact: Phone Email Fax Mail

Ethnicity: Hispanic or Latino? Yes / No

If email please provide:_____

Race (circle one): White American Indian Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander

Do you have Medicare or Medicade insurance? Yes / No

Please initial once form is completed:_____

UNITED EYE CENTERS, P.C.

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At United Eye Centers P.C., we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Karen Heagerty 303-761-2020 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the United Eye Centers, P.C. Notice of Privacy Practices.Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____