## WELCOME TO CARENCRO EYE CLINIC! PLEASE COMPLETE THE FORM BELOW AS COMPLETELY AS YOU CAN.

STEP 1 – PATIENT REGISTRATION	STEP 1 –PATIENT REGISTRATION CON'T
Patient Name:	
(Last) (First) (MI) Address:	NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and
(city) (state) (zip)   Social Security No.: - -   Birthdate: / /   Sex: (circle one) Male Female	the practice's legal duties with respect to my protected health information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.
Employer or School: Occupation or Grade: Home Phone :()	/ Responsible Party Signature (Date)
Work Phone: ()     Cell Phone :()     Email Address:	/ Printed Name Relationship to patient
Which method do you prefer to receive appointment reminders: (please circle one) <b>Text Email US Mail</b>	STEP 2 –RECREATIONAL HEALTH INQUIRY
Ethnicity: Hispanic/LatinoNot Hispanic/LatinoUnknown Decline to Answer Race:African AmericanCaucasian(White) AsianAmerican Indian/Alaska Native Native Hawaiian/Pacific Islander Decline to answerOther:	Do you currently wear:Glasses Contacts If currently a contact lens wearer which: Brand of contacts do you wear: Brand of Solution do you use: If prescription is needed, are you interested in: Glasses Contacts
In Case of Emergency, Contact: Name: Relationship: Home Phone:_() Cell Phone:_() Work Phone:_()	<b>**NOTE</b> : If interested in contacts, please be aware that there is an additional charge for contact lens fitting and materials; it is not included in the comprehensive eye. Inquire at front desk for more information.
I authorize the following people to be able to obtain or handle matters in regards to my protected health information on my behalf. I understand that <b>NO ONE</b> will be given information or be allowed to handle <b>ANY</b> matters on my behalf if they are not listed below and that at any time if I wish to add or remove names from	Do you use a computer:YesNO Hrs. /day Please indicate any hobbies or interests: fishinggolfingreadingsewingmusic
this list must be done so in <b>writing</b> :	sportsdancingother: Please indicate which substances you use: AlcoholTobaccoDrugs/other
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				MEDICAL HISTORY (	QUESTIONIA			
PLEASE CIRCLE	ANY OF THE	FOLLOWING CO		HAT <u>YOU</u> CURRENT	LY HAVE OR HAVE HAD IN TH	E PAST:		
Pregnant now			Allergies		Asthma/Respiratory	ΥN		
Eye Diseases	Y N		Diabete	s Y N Type 1 or 2		ΥN		
Eye Injuries	ΥN		Cancer	YN	Heart Disease	ΥN		
Eye Surgery	ΥN		Thyroid	ΥN	High Blood Pressure	ΥN		
Lazy Eye	ΥN		Kidney	ΥN	Nerve Problems	ΥN		
Cataracts	ΥN		HIV/Blo	od YN	Psychiatric	ΥN		
Glaucoma	ΥN		Fever	ΥN	Weight Loss	ΥN		
Skeletal	ΥN		Stomach	n YN	Genitourinary	YN		
Ear	ΥN		Nose	ΥN	Mouth/Throat	ΥN		
PLEASE CIRCLE	ANY OF THE			HAT ARE IN YOUR F	AMILY HISTORY: (mother, fat	her, siblings)		
Blindness	Cataracts	Glaucoma	Diabete	s High Blood	Pressure Retinal Detachm	ents		
Heart Disease	Mac	ular Degenerat	ion	Other Conditions: _				
Please list any and all medications: (prescription or over-the-counter):								
Please list all k	nown drug all	ergies below:						
In case a presc Pharmacy Nam	ription is need ne: r:		out the inforr	her: nation below for w	hich pharmacy you would like	e us to use:		
		ST	TEP 4 –HEAL1	H/VISION INSURAN	NCE			
Insurance Com	pany:				SIGNATURE ON FILE			
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Responsible Party Signature:\_\_\_\_

Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_\_ \*\*Please present insurance cards to front desk upon completion of paper work. Thank You!!\*\* Method of Payment: cash, credit card, Medicaid, Medicare, VSP, other \_\_\_\_

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