ARGOS VISION AND EYECARE CENTER

Registration Form

Patient Information

Name: ☐Mr. ☐Ms. ☐Mrs. ☐Dr. _____
(First) (Middle) (Last)

SSN:___-___-___ Date of Birth: ___/___/___ Sex: Male Female

Street Address (or PO Box):_____

City:_____ State: _____ Zip:_____.

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Life Partner

Phone: (H) ___-___-___ (W) ___-___-___ (Cell) ___-___-___.

May we leave a message on your home, work or cell phone regarding appointment reminders? ☐Yes ☐No

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone:___-___-___.

How did you learn about our practice? ☐Dr. Referral ☐Family/Friend ☐Yellow Pages ☐Google
☐ Insurance Directory ☐ Other _____

Medical Insurance Information

	Primary	Secondary
Insurance Name:		
Member ID #:		
Relationship: (If self, leave next 2 spaces blank)	Self Spouse Dependent	Self Spouse Dependent
Policy Holder Name:		
Policy Holder DOB:		

VISION Insurance Plan Name:_____
Member or Policy ID #:

Your Doctors

*Primary Care Physician: _____ Phone: _____-_____-_____

Referring Physician: _____ Phone: _____-_____-_____

I certify that the information above is accurate and true to the best of my knowledge and is only to be used for treatment, billing, & processing of insurance benefits. I will not hold my physician or any member of Argos Vision and EyeCare Center responsible for any errors or omissions I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize Argos to release and or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I understand that without a proper referral or authorization from my HMO/PPO, I am financially responsible for charges incurred for services rendered by Argos on all dates of service. I understand that I alone am responsible for obtaining my authorization or referral from my HMO/PPO primary physician. I understand that I am responsible for charges incurred for services considered to be non-covered by my HMO/PPO.

Signature:_____ Date:___/___/20___

Summary Notice of Privacy Practices
As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA). This is a brief summary of your privacy rights and the privacy practices of Argos Vision and EyeCare Center and its affiliated facilities. Please also read our FULL Notice of Privacy Practices for a full description of our practices and of your rights. Please review this notice carefully.

Argos Vision and EyeCare Center, along with you Primary Care Physician, Referring Physician, & all other Physicians/facilities who participate in your care are allowed to share medical information with each other as part of an organized health care arrangement for treatment, payment and operational activities. We will use this information in order to provide our patients complete & comprehensive health care services. If you have any questions with wither our summary or Full Notice of Privacy Practices, Please contact Argos Vision and EyeCare Center at (301) 637-3181.

Our Commitment
We are committed to protecting your Private Health Information. As health care providers, Argos Vision and EyeCare Center is required by law to keep health information about you private, to give you our notice about our privacy practices and to follow the practices outlined in our full Privacy Notice.

How We May Use and Disclose Your Information
We may use you private health information, treatment, payment and health care operations. Under certain circumstances, Argos Vision and EyeCare Center may also disclose your private health information for other purposes without your written permission. We may give out information about you for public health purposes: to report abuse, neglect, or domestic violence, for health oversight audits or inspections, for certain approved research purposes, for funeral arrangements or organ donations, to government programs, to workers' compensation, and in emergency situations. We may also disclose health information when required by law, such as in response to a request from law enforcement or in response to a court order. We may also contact you for appointment reminders and to tell you about possible treatment options and health services. In addition may also disclose health information about you to family, friends, relatives or caregivers who may be involved in your care for treatment and payment purposes.

Your Rights Concerning Your Health Information
You may ask to review or receive copies of your health information. There may be a fee for this service. You may ask us to amend health information in your medical or billing records that you believe is in error or incomplete. You may request an accounting of certain disclosures we have made from your records. You may request alternate forms of communications. You may ask us to restrict how we use or disclose your Private Health Information. You may complain to us and to the federal government if you believe your privacy rights have been violated. You have a right to a paper copy of our current Full Privacy Notice. We will consider your request, but we may not agree if we are not required by law to do so.

We reserve the right to make changes to this summary notice and will post a copy of the current Full Privacy Notice in locations where treatment is provided.

In addition:

With this authorization, Argos Vision and EyeCare Center may call home or other designated location and leave a voice mail message, in person or by mail in reference to appointment, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

By signing this form, I am authorizing Argos Vision and EyeCare Center to use and disclose my Protected Health Information to the individuals I have listed on the previous page to act on my behalf for healthcare information.

For specific information, I am aware that I will need to complete the **Consent to Release Protected Health Information Form** prior to information being released as specified in the HIPAA Notice of Information Practices.

I may revoke this authorization in writing at any time.

DATE: _____

PRINT NAME: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

Medical questionnaire

If you are a woman, if there a chance you might be pregnant? Yes No N/A

Do you take any medicated eye drops? Yes No which eye? Right Left Both

How many times/day: _____

Do you wear glasses? Yes No Do you wear contact lenses? Yes No

What is your profession? _____

Do you have any activities with special vision requirements? (Pilot, firearms, art, etc):_____

Do you take any other medications? Yes No

Please list names only:_____

Have you had any previous eye problems or eye surgeries? Yes No Explain:_____

_____

Do you have allergies to medication? Yes No Medication and reaction experienced?_____

_____

Do you smoke? □ Yes □ No Formerly *If yes, how many packs per day?* _____ *How many years*? _____

Do you drink alcohol? □ Yes □ No If *yes, how much?* _____

Past Medical History

Do you have any of the following conditions? (Check those that apply) □ **None**

□Seasonal allergies	□Heart Attack	□High Cholesterol	□Asthma	□Enlarged prostate
□Blood Clots	□Eczema	□Stomach Ulcers	□Cronh's disease	□Diabetes
□Gallbladder Disease	□Stroke	□Arthritis	□Seizures	□Migraines
□Chest pain	□Hepatitis	□HIV or AIDS	□Irregular heart	□Irritable bowel disease
□Anemia	□Osteoporosis	□High Blood Pressure	□Depression	□Other
□Cancer	□Anxiety	□Kidney Disease	□Liver disease	
□Heartburn/Reflux	□Poor Breathing		□Thyroid disease	

Have you recently experienced any of these symptoms? (Check those that apply) □ **NONE**

General

□fatigue □fevers □weight gain/loss

Ear/Nose/Throat

□hearing loss □cold or flu-like symptoms □sinus problems

Psychological

□emotional problems □psychological problems

Skin

□rashes

Blood

□easy bruising/bleeding

Gastrointestinal

□abdominal pain □nausea □vomiting □constipation

Breathing

□cough □wheezing □shortness of breath

Heart

□chest pain or pressure □palpitations (irregular heartbeat) □Leg swelling

Genital/Urinary

□pain with urination □blood in urine □genital sores

Hormonal

□excessive thirst □feeling cold or hot □bulging eyes

Neurological

□headaches □dizziness □numbness of extremities

Musculoskeletal

□arthritis □joint swelling □weakness

Does anyone in your family have any of the following**:** □ N**one**

□ Macular Degeneration Relation: _____

□ Glaucoma Relation: _____

□ other eye disease Relation: _____