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Patient information

Patient:

Name: _____ DOB: _____ SSN: _____

Street : _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency:

Contact: _____ Telephone: _____

Email: _____ Primary Care Physician: _____

Responsible Party

(Please fill out this section if different than above)

Full Legal Name: _____ SSN: _____

Billing Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

(Please present all insurance cards and photo i.d. to front desk upon arrival)

Policy Holder: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated for any services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or these benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked. **I understand that I am financially responsible for all charges whether or not covered by my insurance company. We only file insurance with companies with whom we are contracted. All Secondary insurance filing is the responsibility of the patient.**

I have read and understand the above statements.

_____ _____

Signature Date

Medical Health History Questionnaire

What is your preferred form of communication from our office

1. email _____ 2. Mail_____; 3. Fax_____; Phone: _____

Demographics: Sex_____;Ethnicity_____; Preferred language;_____Race:_____

Are you diabetic?_____If yes who is primary care provider? _____

What was your last A1C?_____When was it taken and where?_____

Have you had a pneumonia vaccination? _____ Do you use tobacco?_____Frequency?_____

Your chief complaint today:_____

Onset?_____ Which eye?_____ Pain? _____ Duration?_____

Have you had any eye surgeries? If yes, Please List

Date	Procedure	Surgeon	Eye

Personal and Family Ocular History:

Condition	Self:	Relation of Family Member:		Condition	Self:	Relation of Family Member:
Diabetic Retinopathy				Blindness		
Cataracts				Strabismus/ amblyopia		
Macular degeneration				Chronic Dry Eye		
Glacuoma				Retinal Detachment		

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Review of systems: (Conditions with your general health)

Your general health status?_____

Integumentary: (Skin problems)_____

Ears/Nose/Throat/Mouth:_____

Respiratory:(COPD, Asthma)_____

Cardiovascular:(Heart, Blood pressure, Stroke)_____

Gastrointestinal:(Digestion, Bowl) _____

Genitourinary tract:(Bladder)_____

Musculoskeletal:(Arthritis)_____

Neurological:(Seizure, headache)_____

Endocrine:(Diabetes, Thyroid dysfunction)_____

Hermatologic:(Blood disorder)_____

Psychiatric:(Depression, ADD)_____

Allergies/Immunologic: (MS, food or drug allergies)_____

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Please List all Medications and Dosage		This Portionis for office use only						

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Designation of personal Representative

Amarillo *I*Care
3401 Soncy, Suite 100
Amarillo, Texas 79119

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to nomination that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Designation section

I,_____ (Print name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information the pertains to me.

_____

(Print Name or Personal Representative)

The authority of this person when acting as my personal representative is restricted to the following functions:

Description:
(Note: In lieu of a description of the privileges to be afforded the personal representative, alternative text may say:
“This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.”)

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Amarillo *I*Care, PC, I further understand any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature Date

Revocation Section

I hereby revoke this designation of a personal representative.

_____ _____

Signature Date

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Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received or been given the opportunity to read the Privacy Notice.

Patient or Personal Representative Signature

Date

If patient's personal representative signature appears above, please describe personal representative's relationship to the patient:

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