WELCOME TO HAWTHORNE VISION CENTER

Name:_____ **Salutation:** ☐ **Dr.** ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**
Home Address:_____
Gender:_____ **Preferred to be addressed as (Nickname):**_____
Employer:_____ **Occupation:** _____ ☐ **Retired**
Please list your PCP: **Email:** _____

Dr._____ **at** _____ **phone**_____

Last eye exam _____ **at** _____
Do you wear contacts? ☐ **No** ☐ **Yes,** how often? _____ • **Are you wearing any today?** ☐ **No** ☐ **Yes**

Have you ever had?:

- ☐ Glaucoma
- ☐ Cataract - Cataract surgery, year(s)_____
- ☐ Retinal problem
- ☐ Eye surgery, including LASIK, PRK, or RK
- ☐ Lazy, crossed or wandering eye
- ☐ Serious eye injury, DATE:_____
- ☐ Serious eye infection, DATE:_____
- ☐ Other eye diseases, please list:_____
- ☐ **I do not have any of the above or other eye conditions**

Hobbies?

- ☐ Fishing
- ☐ Boating
- ☐ Reading
- ☐ Motorcycling
- ☐ Swimming
- ☐ Water sports
- ☐ Computer
- ☐ Tennis/ Racquet/Handball
- ☐ Playing a musical instrument
- ☐ Golfing
- ☐ Gardening
- ☐ Acting/dancing
- ☐ Crafts
- ☐ Biking
- ☐ Snow sports
- ☐ Running
- ☐ Video games
- ☐ Painting
- ☐ Other:_____

Family History

(please list who)

- ☐ Glaucoma: _____
- ☐ Crossed, wandering or lazy eye (Circle)
- ☐ Macular degeneration:_____
- ☐ Cataract: _____
- ☐ Other, list what and family member:

_____

How many hours a day do you spend reading or doing desk work, including computer work?: _____

Roughly how far away are your eyes from the computer screen?: _____

Is the screen:
☐ **AT** ☐ **ABOVE** ☐ **BELOW EYE LEVEL**

Tell us about your health

(Please check if they apply to you)

- ☐ Cancer, type_____
- ☐ Hearing loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Asthma
- ☐ Other:
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex
- ☐ Shingles
- ☐ High Cholesterol
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Seasonal Allergies

How did you hear about our office?

- ☐ Family Member/ Friend (name)

_____

_____

- ☐ Internet search
- ☐ Insurance list
- ☐ Other:_____

_____

Please list all current medications

_____

_____

_____

Are you?

- ☐ Pregnant
- ☐ Breastfeeding
- ☐ Allergic to latex
- ☐ Allergic to medications

List of medications you are allergic to:

_____

YES! There's more on the back!

Meaningful Use

Meaningful Use is a US government initiative designed to ensure the highest quality of healthcare through the use of electronic health records. Healthcare providers are strongly encouraged to participate in this program. Please help us comply with the government regulations by answering the following questions (all terms are specified by the US government's Meaningful Use Program).

Race

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Indian: Country of India
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other:_____
- ☐ Prefer not to say

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Prefer not to say

Preferred method of contact:

- ☐ Text _____
- ☐ Phone _____
- ☐ Email _____

Do you drink alcohol?

☐ Yes, how many per week?_____ ☐ No

Do you smoke?

☐ Yes, how often? _____ ☐ Not currently ☐ Never

Preferred language

_____

***** PLEASE SIGN **ALL THREE** POLICY NOTIFICATIONS*****

1) Payment Policy: Payment is required when services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Hawthorne Vision Center directly.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a minimum of a $ 50 collections fee."

Signed _____ Date_____

2) Privacy Policy: This allows us to bill your insurance and make medically necessary referrals.
"I hereby authorize release of information to my insurance company or to any health care professional when necessary for my health care or billing."

Signed _____ Date_____

3) HIPAA Policy: Due to new HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take to protect your personal health information. A copy is attached to this form. Please ask the receptionist if you would like an additional copy of this document.

☐ don't want a copy ☐ received copy

Signed _____ Date_____

Thank you for your help. Now we know just what type of care and services to provide.
Please let us know if you have any special needs not addressed on this form.