DR. HELEN KNISLEY AND ASSOCIATES
PATIENT REGISTRATION FORM

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We are looking forward to providing the best services to maintain your eye health. PLEASE PRINT LEGIBLY.

Today's Date: _____ ❑ Appointment ❑ Walk-in **Purpose of visit**: Glasses exam____ Contact lens fitting____ Office visit____

PATIENT INFORMATION

Patient's last name:	First:	MI:	Age:	Sex: M F	Birthday:
Address:	City:		State:		Zip:
Home phone # ( )	Cell phone # ( )		Social Security #		
OCCUPATION:	**EMAIL:**				

PRIMARY INSURANCE HOLDER INFORMATION

Last name:	First:	Sex: M F	Birthday:	Social Security #
Insurance name:	Member ID#	**Relationship to patient: □ self □ spouse □ parent**		
Address:	City:	State:	Zip:	

SECONDARY INSURANCE HOLDER INFORMATION

Last name:	First:	Sex: M F	Birthday:	Social Security #
2nd Insurance name:	Member ID#	**Relationship to patient: □ self □ spouse □parent**		

OCULAR (EYE) HISTORY

Date of last eye exam _____ **Doctor's name** _____

Do you wear glasses? □ Yes □ No □ All the time □ Occasionally □ Distant only □ Reading only

Do you wear contacts? □ Yes □ No □ Disposables □ Daily □ Overnight Brand _____

Do you have any problem with contacts? □ Dryness □ Itchiness □ Redness □ Poor vision

Do you use computer? □ Yes □ No How many hours/days? _____

Do you have the following?

Blurred vision	□ yes	□ no	Retinal detachment	□ yes	□ no	Double vision	□ yes	□ no
Dry eyes	□ yes	□ no	Tired/ Eye strain	□ yes	□ no	Eye pain	□ yes	□ no
Floaters	□ yes	□ no	Headaches	□ yes	□ no	Light sensitivity	□ yes	□ no
Loss of vision	□ yes	□ no	Red eyes	□ yes	□ no	Flashes of light	□ yes	□ no
Watering eyes	□ yes	□ no	Itchy eyes	□ yes	□ no	Cataracts	□ yes	□ no
Lazy eye/eye turn	□ yes	□ no	Distorted vision	□ yes	□ no	Glaucoma	□ yes	□ no
						Macular Degeneration	□ yes	□ no

Have you had any eye injury/ surgery? □ Yes □ No If yes, why_____

Are you taking any eye medication? □ Yes □ No If yes, why _____

Do you have any family history of? □Blindness □Cataracts □Glaucoma □Lazy eye/eye turn □Macular degeneration □Retinal detachment □ color deficiency

MEDICAL HISTORY

Date of Last Exam **Primary Physician Name**

List all medications currently taking:

Are you allergic to any medications Yes____ No____ **List all drug allergies:**

Do you smoke? ____ yes ____No ____Quit **Alcohol or drug dependency?** ____ Yes ____No ____Quit

Check if you have the following:

Are you pregnant?	□ yes	□ no
Post-partum/nursing?	□ yes	□ no
Fever/ weight loss/ gain	□ yes	□ no
Skin problems	□ yes	□ no
HEADACHES		
Headaches/ migraine	□ yes	□ no
Seizure	□ yes	□ no
ENDOCRINE		
Diabetes	□ yes	□ no
Thyroid disease	□ yes	□ no
EARS/ NOSE/ MOUTH/ THROAT		
Allergies/ hay fever	□ yes	□ no
Sinus congestion	□ yes	□ no
Runny nose	□ yes	□ no
Post Nasal drip	□ yes	□ no

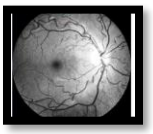
RESPIRATORY		
Asthma	□ yes	□ no
Chronic Cough	□ yes	□ no
Dry Throat/ mouth	□ yes	□ no
VASCULAR		
Heart Disease/ heart attack/ surgery	□ yes	□ no
High Blood Pressure	□ yes	□ no
Aneurysm	□ yes	□ no
High Cholesterol	□ yes	□ no
GASTROINTESTINAL		
Diarrhea	□ yes	□ no
Constipation	□ yes	□ no
GENITO-URINARY		
Kidney/ bladder disease	□ yes	□ no
Prostate	□ yes	□ no
Genitals	□ yes	□ no

BONES/ JOINT/ MUSCLES		
Rheumatoid Arthritis	□ yes	□ no
Muscle pain	□ yes	□ no
Joint pain	□ yes	□ no
LYMPHATIC/ HEMATOLOGIC (blood)		
Anemia	□ yes	□ no
Bleeding Disorders	□ yes	□ no
Autoimmune disease (Lupus, MS)	□ yes	□ no
Depression or anxiety	□ yes	□ no
Infectious Disease (HIV/ Hepatitis/ STD)	□ yes	□ no

If answered yes please explain treatments:

Do you have any family history of? □ stroke □ cholesterol □ cancer □ diabetes □ high blood pressure □ heart problems

DIGITAL RETINAL PHOTOGRAPHY



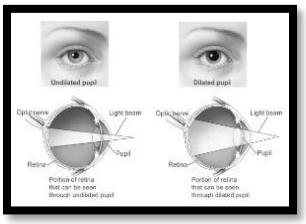
As part of comprehensive exam, we recommend a special screening diagnostic procedure called Digital Retinal imaging. This screening procedure consist of taking digital photographs of the back of your eyes. The pictures can be viewed immediately by the doctor. It provides a much wider field of view than most traditional non- dilated retinal exams, therefore allowing the Doctor to evaluate eye diseases such as glaucoma, macular degeneration, or diabetic retinopathy.

The best feature is digital recording. Since the photos are digitally saved, they serve as a documentation of the current condition of your eyes, which then can aid in the tracking of any changes over the years should anything occur in the future. The entire procedure takes less than 3 minutes, and there are no side effects. The Doctor highly recommends that all patients have this procedure done to allow the Doctor to utilize the best tools available to assess the health of the eyes, thus provide the highest level of eye and medical care. **The charge for this procedure is $25.00**.

- ☐ I **wish** to have retinal photography performed today
- ☐ I **do not wish** to have retinal photography performed today

PATIENT OR GUARDIAN SIGNATURE_____ DATE_____

DILATION



Dilation is a diagnostic procedure to evaluate the back of the eyes by dilating (opening) the pupils. The Doctor highly recommends dilation as part of comprehensive eye exam to provide the highest level eye care for all patients. Dilations is best combined with digital retinal photography to thoroughly evaluate and permanently record the eye health. Dilation is also recommended in children whose cooperation is limited during eye exam.

Dilation procedure consists of using eye drops to open the pupils; **side effects for most patients are light sensitivity and blurred vision, and usually last about 4-6 hours**. **We highly recommend that you have someone drive for you when you have your eyes dilated**. If you experience any or of the following symptoms after dilation, seek immediate medical attention: Red/ painful eyes/ blurry or steamy vision/ nausea or headache. The charge for this procedure is $ 65.00. Some insurance companies may cover procedure, ask office for details. **With no insurance DISCOUNTED PRICE is $ 45.00**

- ☐ I **wish** to have my eyes dilated today
- ☐ I **do not wish** to have my eyes dilated and assume the responsibility of having an eye exam without dilation.

PATIENT OR GUARDIAN SIGNATURE_____ DATE_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____Acknowledge that Dr. Helen Knisley's office is billing my medical and/ or vision insurance (s) as a courtesy only. **For any or all reason if my insurance (s) delays or does not pay Dr. Helen Knisley's office for any/ or all of my bill, I know that I am solely responsible for any and/ or all of my bill, including fees or any other fees accumulated.**

HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

PATIENT'S NAME_____ **DATE OF BIRTH**_____

_____ _____

SIGNATURE OF PATIENT/ GUARDIAN **DATE**