Dr. Helen Knisley & 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 look forward to providing the best services to maintain your eye health. PLEASE PRINT LEGIBLY.

Date: ____/____/_____	**Purpose of visit** (Circle): Glasses Exam/ Contact Lens Fitting/ Office Visit	**Circle One**: Appointment/ Walk-in

Patient Information

Last name: First: MI: | Age: | Sex: M F | Birthday:

Address: City: State: Zip:

Cell Phone: ( ) | Other: ( ) | Social Security #:

Email: Occupation:

Insurance Information (If self, top line only)

Insurance name: Member ID: Relationship to patient: **self/ spouse/ parent**

Last name: First: | Sex: M F | Birthday:

Address: City: State: Zip: |Cell Phone:

Ocular History

Date of last eye exam: _____ Doctor's Name: _____
Do you wear glasses: Yes/ No **If yes**: All the time/ Occasionally/ Distance only/ Reading only
Do you wear contacts: Yes/ No **If yes**: Disposables/ Daily/ Overnight/ Brand: _____
Do you have any problems with contacts? Yes/ No **If yes**: Dryness/ Itchiness/ Redness/ Other: _____
Do you use electronic devices? Yes/ No **If yes**: How many hours/days? _____

Circle if you experience the following:

Dry eyes Floaters Watering eyes Lazy eye/eye turn Retinal detachment Tired/eye strain Red eyes

Itchy eyes Double vision Flashes of light Cataracts Glaucoma Macular degeneration Other:_____

Have you ever 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: _____ Doctor's Name: _____
List of 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

Circle if you experience the following:

Pregnant Post-partum/nursing Headaches/migraines Seizure Diabetes Thyroid disease Allergies/ hay fever
Asthma Heart disease Heart attack Heart surgery High blood pressure Aneurysm High cholesterol
Kidney/bladder disease Prostate Rheumatoid arthritis Anemia Bleeding disorder Depression/ anxiety
Autoimmune disease (Lupus/MS) HIV/ Hepatitis/ STD Cancer Other:_____

Do you have any family history of: Stroke |Cholesterol |Cancer | Diabetes |High blood pressure |Heart problems

Optos Map

As part of comprehensive exam, the Doctor 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 charge for this procedure is $25.00**.

☐ **YES,** I wish to have Optos Map performed today.
☐ **NO,** I do not wish to have Optos Map 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. Dilation is 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 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**

☐ **YES,** I wish to have dilation performed today.
☐ **NO,** I do not wish to have dilation performed today.

Patient OR Guardian Signature_____ **Date:** _____

Acknowledgment of Financial Responsibility

I, _____ acknowledge that Dr. Helen Knisley's office is billing my vision insurance(s) as a courtesy only. **For any reason if my insurance(s) delays or does not pay Dr. Helen Knisley's office for any/all of my bill, I know that I am solely responsible for any/ all of my bill including fees or any other fees accumulated. I understand that there are no refunds on services rendered.**

HIPAA Acknowledgement & Consent

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 healthcare 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 healthcare 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 healthcare 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 or she has received a copy of our HIPAA practices.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

Patient's Name: _____ **Date of birth**: _____

Patient/ Guardian Signature: _____ **Date**: _____