Union Optical Plan

Dr Mike Lockhart Jr & Assoc Inc

Patient Registration Form:

Name First ________________________________ (MI) ____ (Last)____________________________________ Gender ☐M ☐ F

Address____ City____________________________ State ________ Zip__________

Telephone (H)_________________________ (Cell/Work)______________________ DOB ____/____/_____ SS#________________

Occupation ____________________ Employer________________ Email_________________________________ Single☐ Married ☐

Health Insurance Carrier _____________________________________Vision Insurance Carrier_______________________________

Have you ever been to this office before ☐ YES ☐ NO When was your Last Eye Exam _____________________________________

Eye Health History: (Please check all that apply)

☐ Blurred Vision	☐Burning	☐Discharge	☐Pain/ Soreness to eyes
☐ Halos/ Glare	☐ Itching	☐ Headaches	☐Contact Lens Problems
☐ Flashes /Floating Spots	☐ Dryness	☐ Watering eyes	☐Peripheral Vision Loss
☐ Redness	☐ Double Vision	☐Foreign Body Sensation	☐Other ______________

Have you ever been told you have any of these or have any family history of these? (Please Check all that apply)

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment	☐ Melanoma of the Eye
☐ Dry Eye	☐ Macular Degeneration	☐ Retinitis Pigmentosa	☐ Corneal Dystrophy
☐ Lazy Eye	☐ Crossed Eye	☐ Blindness	☐Other_______________

Do you now wear contact lenses? ☐ YES ☐ NO If no have you worn them in the past? ☐ YES ☐ NO

Are you interested in contact lenses for occasional use? ☐ YES ☐ NO Are you interested in LASIK ☐YES ☐NO

Dilation informed consent: Dilation is recommended every 2-3 years, even in healthy eyes. Dilation may be required more frequently by your eye doctor for many ocular and systemic conditions. Many Serious and sometimes vision threatening conditions cannot be accurately diagnosed or detected without dilation. Dilation will make you light sensitive and will make your distance and reading vision blurry. Driving is usually safe when dilated, and the patient assumes all risk of operating a motor vehicle, as well as any other visually demanding tasks, while dilated. An option to this is Optomap photos that can be taken at a cost of **$25.00**

DO YOU WISH TO BE DILATED TODAY ☐ YES ☐ NO WOULD YOU PREFER TO HAVE OPTOMAP INSTEAD FOR $25.00? ☐ YES ☐ NO

Signature: pt or legal guardian ____

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY TO YOU, CIRCLE IF FAMILY HISTORY)

Approximate Height ______	☐ Anxiety	☐ Ulcers	☐ Thyroid Disease
Approximate Weight______	☐ Bipolar disorder	☐ Currently Pregnant	☐ Rheumatoid arthritis
☐ Sinus Congestion	☐ Heart disease	☐Degenerative Disk	☐ Lupus
☐ Hearing Loss	☐Artery disease	☐ Muscular Dystrophy	☐ Sjogren's Disease
☐ Multiple Sclerosis	☐Hypertension	☐ Fibromyalgia	☐ HIV/AIDS
☐ Cerebral Palsy	☐ High Cholesterol	☐ Osteogenesis	☐ Smoker
☐Parkinson's Disease	☐Asthma	☐ Rosacea	☐ Consume Alcohol
☐Stroke	☐COPD	☐ Shingles	☐ Depression
☐ Colitis	☐ Diabetes Type 1	☐ Diabetes Type 2	Other________________

Medications: (Please list any current medications you take, if you don't know the name then what you take it for)

1.________________________ 2. _________________________ 3. __________________________ 4. ___________________________

5.________________________ 6. _________________________ 7. __________________________ 8. ___________________________

Are you allergic to any medications? ☐YES ☐ NO Please list____

Are there any other conditions we should know about? ____

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HIPPA PRIVACY

I acknowledge and agree that I have been informed that this office abides by the HIPAA laws and I am entitled to a copy of the Notice of Privacy practices for review and, if desired, to keep for my records on the date identified below.

I understand that the Office may use and disclose necessary person health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the office to perform its administrative duties, provide me with eye care services and products, process my Vision/ Medical insurance benefits claims and communicate with me regarding vision care services/ products provided by the Office (for example, mailings of exam reminders or information about services/ products provided by the Office).

X____ ______________________________________

Patient or legal guardians signature Date

I authorize Dr Mike Lockhart Jr & Associates Inc. to release my complete medical records and other documentation made by doctors or personnel for the entire time I was treated by the Practice to the following family members, friends or other care givers who contact us for purpose of providing them with information related to my treatment and/or payment obligations:

Name:____ Relationship____

Name:____ Relationship____

I understand the practice may need to contact me for purposes related to my treatment such as; appointments, referrals, and billing business.

My preferred method of communication is:

☐ Phone/ text (voice messages may be left

☐ Email

☐ Postcard

☐ Any of the above

X____ ____

Patients signature or patients legal representative Date

I hereby authorize the use of my above email or address. I understand I can revoke this authorization at any time in writing

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Insurance/ Medicare Release

I authorize the release of any information required to process an insurance claim. I understand that I am responsible for payment of any amounts not covered by my insurance plan. By signing below, I submit all health information disclosed is accurate. I authorize the Office to receive insurance payments directly for the services I have received.

X____ ____

Patient signature or patients legal representative Date

Due to new healthcare regulations involving healthcare portals and meaningful use of patient records, we need an email address on file.