# PATIENT INFORMATION SHEET

Name: ______________________________________ Date of Birth: _____/____/____ Today's Date: _____/_____/____

Home Phone #: ____________________ Cell Phone #: ____________________ e-mail address: ___________________________

Street Address: _____________________________________ City, State, Zip: __________________________________________

Sex (M/F): ____ Employed (Y/N): ____ Student: (FT/PT) ____ Patient's Social Sec. # ___________________________________

Employer/School Name: ___________________________________ Marital Status ___________________________________

Responsible Party: ______________________________ SSN: __ __ __-__ __-__ __ __ __ Date of Birth: _____/_____/_____

Relationship to Patient: ____________________________________ Billing Address: _____________________________________

Allergies: ___________________________________________________________________________________________________

Referred by: __________________________________ Family Physician: ______________________________________________

## EYE DISEASE:

List any known eye disorders you have, eye surgery you have had and when:

_________________________________________________

_________________________________________________

## OTHER MEDICAL CONDITIONS:

List past and present medical conditions, major illnesses and injuries:

_________________________________________________

_________________________________________________

## LIST MEDICATIONS YOU ARE TAKING:

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

**DO YOU HAVE TROUBLE WITH:** PLEASE CIRCLE

| | |
|---|---|
| High Blood Pressure | NO YES |
| Heart Attack | NO YES |
| High Cholesterol | NO YES |
| Stroke | NO YES |
| Asthma | NO YES |
| COPD/Emphysema | NO YES |
| Hearing Loss | NO YES |
| Dry Throat or Mouth | NO YES |
| Arthritis | NO YES |
| Cancer | NO YES |
| Headaches | NO YES |
| Thyroid Problem | NO YES |
| Diabetes | NO YES |
| Anemia | NO YES |
| Hay Fever | NO YES |

**FAMILY HISTORY:**

| | |
|---|---|
| Cataract | NO YES |
| Glaucoma | NO YES |
| Macular Degeneration | NO YES |
| Retinal Detachment | NO YES |
| Blindness | NO YES |
| Diabetes | NO YES |
| Retinitis Pigmentosa | NO YES |

FAMILY MEMBER: ___________________

**SOCIAL HISTORY**:

Occupation: ___________________________

Smoking: ____ Never ____Quit ______Years Ago

____ppd for __________Years

Alcohol: _____Never _____Occasional ______Moderate

Other recreational substance intake: _____NO _____ YES

## INSURANCE INFORMATION

**PRIMARY INS. CARRIER:** PHONE #**:**

ADDRESS: ______________________________ ID #: ______________________________

CITY: ____________________ST: ______ ZIP ________ GROUP NAME/#: ______________________

POLICY HOLDER'S NAME: ________________________________________________

POLICY HOLDER'S ADDRESS: ____________________ PHONE #: ____________D.O.B. ___/___/___

POLICY HOLDER'S EMPLOYER NAME: ______________________ SSN: _____-____-_____

RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WIFE CHILD PATIENT OTHER

**SECONDARY INS. CARRIER:** ____________________ PHONE #: ____________________

ADDRESS: ______________________________ ID # ______________________________

**PLEASE READ**

I authorized treatment of the person named above and agree to pay all fees and charges for such treatment.

I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with
my insurance carrier, however, the financial responsibility for services rendered to a patient ultimately rests with the patient of responsible party.

I understand that my co-pay and/ or any coinsurance monies are due at the time of service. If I do not have insurance or my charges are not to
be filed with insurance, payment in full is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees (33.33%) and any other court costs or costs of collection.

I here by authorize assignment and payment directly to Bruce J. Keenan O.D., P.L.C. all benefits due me for services provided by them.

______________________ ______________________________ ____________________
Patient Signature Signature Authorized Person Date

## HIPPA STATEMENT

I have read BRUCE J. KEENAN O.D. , ***Notice of privacy practices***.

I hereby authorize BRUCE J. KEENAN O.D., to furnish, to my insurance company or authorize agency, information regarding my protected health information, for the purpose of treatment, payments or health care operations. I further authorize the physician(s) of BRUCE J. KEENAN O.D., to consult as needed in their sole direction with other medical providers regarding my medical care.

I wish to place the following restrictions concerning the disclosure of my protected health information

______________________________
Signature of Patient/ Parent/Guardian

BRUCE J. KEENAN O.D., can discuss my medical condition/information with the following:

| | | | | | |
|---|---|---|---|---|---|
| Spouse | YES | NO | Children | YES | NO |
| Parents | YES | NO | Friends | YES | NO |

Please specifically list the names of friends that we may talk with