Stellar Vision Optometry, P.C.

85-18 Queens Blvd, Elmhurst, NY 11373 Tel: (718) 303-0393 Fax: (718) 303-1062

PATIENT REGISTRATION FORM 登记表

Name (**LAST**, First)姓名: _____ Date of Birth 出生日期: ___ /___ / _____ Gender 性别: ☐ Male ☐ Female Address: _____ Apt. _____ City: _____ State: _____ Zip Code: _____ Cell/Home 手機/家庭: (_____)_____ Email: _____ ➢ Check this box if you **do not** wish to receive text messages for appointment reminders ☐ Preferred language: ☐ English ☐ 中文 ☐ Español	➢ Last four digit Social Security No.工卡號碼: XXX-XX-_____ Marital Status: ☐ Single 單身 ☐ Divorce 離婚 ☐ Married 已婚 ☐ Other 其他 Emergency Contact 親戚名字: _____ Relation 關係: _____ Phone # 電話號碼: (_____) _____
INSURANCE INFORMATION **Primary Medical Insurance 保險公司名稱** _____ Policy No. _____ Subscriber:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insurance Holder (If other than self) 保險人名字 _____ Date of Birth 保險人出生日期 ___ / ___ / ___	**Vision/Eyeglass/Contact lens service plan** Plan name:_____ Subscriber: _____ Coverage No.:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insurance Holder (If other than self) 保險人名字 _____

Stellar Vision Optometry, P.C.

85-18 Queens Blvd, Elmhurst, NY 11373 Tel: (718) 303-0393 Fax: (718) 303-1062

Primary Care Physician: _____

Phone # 電話號碼: (_____) _____

Address: _____ Apt. _____

City _____
State _____ Zip Code _____

Date of last physical exam: _____

- **NEW YORK STATE MANDATORY ELECTRONIC PRESCRIBING for MEDICATIONS**

In New York State, Practitioners are now mandated to **electronically** prescribe both controlled and non-controlled substances effective March 27, 2016.

Name of pharmacy: _____

Pharmacy's phone #: (____) _____

Pharmacy's address: _____

_____

- **Do you authorize Stellar Vision Optometry, P.C. to access your medication listed from the above pharmacy? □ Yes □ No**

Explanation of Insurance

Your insurance plan will pay for medically necessary eye care, involving diagnosis and treatment of eye diseases.

As the patient, you are responsible for your insurance co-payments, and/or deductible and for any services not covered by your insurance.

Assignment of Benefits

The signature on this form indicates the assignment of my claim to the doctor and permission to see all insurance forms in my name. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Patient Note: We assume that you are eligible for benefits, if this is not the case you will be billed for unmet deductible and/or co-payments.

Signature on file

I authorize Stellar Vision Optometry, P.C. to use this authorization instead of my actual signature on my insurance submissions. I authorize the release of information to my insurance companies. I authorize payment directly to Stellar Vision Optometry, P.C. when applicable. I understand I am responsible for payment of any charges for all services not covered by insurance companies. I understand that all co-payments must be paid in full on day of services rendered. I have received a copy of the HIPAA policy.

Signature: _____ Date: _____

Stellar Vision Optometry, P.C.

85-18 Queens Blvd, Elmhurst, NY 11373 Tel: (718) 303-0393 Fax: (718) 303-1062

General Medical Information

- **Are you or could you be pregnant**?:

  □ Yes □ No □ not applicable

- **Do you have problems with any of these systems**?

Cardiovascular (Heart)	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Muscles / Bones	□ Yes	□ No
Ears / Nose / Throat	□ Yes	□ No
Integumentary (Skin)	□ Yes	□ No
Respiratory (Lungs)	□ Yes	□ No
Headaches	□ Yes	□ No
Urinary / Genital	□ Yes	□ No
Endocrine (glands)	□ Yes	□ No
Blood / Lymph	□ Yes	□ No
Allergic / Immunologic	□ Yes	□ No
Nervous System	□ Yes	□ No
Gastrointestinal	□ Yes	□ No
Psychiatric	□ Yes	□ No

Please explain if necessary: _____

Vision/Eye Information

Date of last eye exam: _____

- **Do you have any of the following vision or eye problems**?

□ NO VISION PROBLEMS

□ Blurry vision ALL distances	□ Dryness
□ Blurry distance vision	□ Redness
□ Blurry computer vision	□ Burning
□ Blurry reading vision	□ Itching
□ Floating spot(s) in vision	□ Tearing
□ Flashes of light in vision	□ Discharge
□ Double vision	□ Lump of eyelid
□ Eye Pain or Discomfort	□ Headaches
□ Broken glasses	□ Lost glasses

- **What is your reason(s) for your visit today**?

□ Vision problem

□ Eye problem / Emergency, please describe: _____

_____

Diabetes Questionnaire

- **Do you have Diabetes?** □ Yes □ No

  If **Yes** what type? □ Type I □ Type II

Date of diagnosis:_____

Last blood sugar count:_____ Last A1C%: _____

Surgical History

- **Have you had any medical surgeries or procedures**

  □ Yes □ No

Procedure: _____ Date _____

Procedure: _____ Date _____

Procedure: _____ Date _____

Social History

- **Are you a smoker?** □ Yes □ No

Former smoker? □ Yes □ No

How many years have you smoked? _____ year(s)

How many pack(s) per day? _____ pack(s)

_____

□ Diabetes Eye Exam

□ First time contact lens fitting

□ Renew current contact lenses

□ Interested in contact lens fitting

□ Other: _____

- **Do you wear glasses?** □ Yes □ No
- **Do you wear contact lenses?** □ Yes □ No

  If **Yes**, what brand do you wear? _____

- **Have you ever been told that you have any of the following eye condition?**

□ NO EYE CONDITIONS

□ Cataract

□ Glaucoma

□ Macular degeneration

□ Retinal detachment

□ Eye Turn / Strabismus

□ Lazy Eye / Amblyopia

□ History of eye surgeries, please explain: _____

_____

□ History of eye trauma or injury, please explain: _____

_____

➢ **How many times** in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____	

Allergies	**Current MEDICAL Medications and EYE Drops or Medication(s)**
➢ Do you have any Allergies to **medication**(s) □ Yes □ No If **Yes**, what medication are you allergic to and what reaction did you experience? Please explain: _____ _____ ➢ Do you have any **other** Allergies(s) □ Yes □ No If **Yes**, what is your Allergy and what reaction did you experience?: Please explain: _____	➢ **Please list ALL your current medication(s):** NO MEDICATIONS TAKEN □ Name and Dosage: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____ 7) _____ 8) _____

Family History

Stellar Vision Optometry, P.C.

85-18 Queens Blvd, Elmhurst, NY 11373 Tel: (718) 303-0393 Fax: (718) 303-1062

Do you have a relative who has a history of any of the following medical conditions?

If Yes, please described your relationship to that person (i.e. Mother, paternal grandfather…).

Diabetes	□ Yes	□ No	Relation: _____
High Blood Pressure	□ Yes	□ No	Relation: _____
Glaucoma	□ Yes	□ No	Relation: _____
Cataracts	□ Yes	□ No	Relation: _____
Macular Degeneration	□ Yes	□ No	Relation: _____
Retinal Detachment	□ Yes	□ No	Relation: _____

Don’t forget to sign your HIPPA agreement on the back of this page

Stellar Vision Optometry, P.C.

85-18 Queens Blvd, Elmhurst, NY 11373 Tel: (718) 303-0393 Fax: (718) 303-1062

Patient HIPPA Awareness Agreement

With my permission, Stellar Vision Optometry, P.C. may use and disclose protected health information about me to carry out treatment, payment and health care operations.

With my permission, the office or representative of Stellar Vision Optometry, P.C. may call my home or other designated locations and leave a message on voicemail or with a person in reference to any item(s) that may assist the practice in carrying out necessary health care operations, such as appointments, reminders, insurance matters and any information pertaining to billing and collections or my medical care, including laboratory results and prescriptions among other health care or administrative matters.

With my permission, the office or representative of Stellar Vision Optometry, P.C. may mail to my home or other designated locations any items that may assist the practice in carrying out health care operations related to me, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. Stellar Vision Optometry, P.C. is not to be held responsible for any damages that may be caused by an unauthorized person attaining such information without my consent. I have the right to request that Stellar Vision Optometry, P.C. restrict how it uses or discloses my personal health information to carry out health care operations. However, Stellar Vision Optometry, P.C. or its representative reserve the right to decline my request, though if it does agree it is bound by this agreement.

By signing this form, I am allowing Stellar Vision Optometry, P.C. to use and disclose my personal health information for my treatment, payment and other reasonable health care operations.

I may revoke my consent in writing for further disclosures except to the extent of any and all information that Stellar Vision Optometry, P.C. has already disclosed in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Date

Print Patient's Name