

# SHEPHERD EYE CENTER PATIENT INFORMATION FORM

## PATIENT INFORMATION

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_ SEX (CIRCLE ONE): M F  
 DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED WIDOWED DIVORCED  
 ADDRESS: \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_  
 SPOUSES NAME: \_\_\_\_\_ SPOUSE'S DATE OF BIRTH \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME: \_\_\_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_ ) \_\_\_\_\_ SEX (CIRCLE ONE): M F  
 ADDRESS: \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: \_\_\_\_\_ POLICY # \_\_\_\_\_  
 GROUP # : \_\_\_\_\_ EFF. DATE: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_  
 NAME OF INSURED: \_\_\_\_\_ DATE OF BIRTH OF INSURED \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: \_\_\_\_\_ POLICY # \_\_\_\_\_  
 GROUP # : \_\_\_\_\_ EFF. DATE: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_  
 NAME OF INSURED: \_\_\_\_\_ DATE OF BIRTH OF INSURED \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_

## AUTHORIZATION FOR PAYMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/AND/OR ANY THIRD PARTY BENEFITS BE MADE TO THE SHEPHERD EYE CENTER ON MY BEHALF FOR ANY SERVICES RENDERED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE/MEDICAID SERVICES AND ITS AGENTS OR ANY THIRD PARTY PAYOR ANY INFORMATION TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE. THIS AUTHORIZATION SHALL REMAIN EFFECTIVE UNTIL REVOKED IN WRITING BY THE PATIENT OR RESPONSIBLE PARTY.

 \_\_\_\_\_  
 SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY

 \_\_\_\_\_  
 DATE

**ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY POLICIES**

My signature below acknowledges the receipt of Shepherd Eye Center's *Notice of Privacy Policies*.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security #

**PATIENT CONTACT**

Shepherd Eye Center staff may need to contact you regarding appointments, test results, financial matters/billing concerns, or other healthcare operation communications. In order to contact you, we need authorization of the following methods of communication.

**BY CHECKING THE FOLLOWING BOXES, YOU AUTHORIZE SHEPHERD EYE CENTER TO CONTACT YOU.**

I authorize Shepherd Eye Center to contact me and leave a message if needed at (check all that apply):

- Home Phone     Cell Phone     Work Phone     Email address

My **PREFERRED METHOD OF CONTACT** is:

Telephone (number) \_\_\_\_\_; Cell (number) \_\_\_\_\_;  
Email: \_\_\_\_\_; Other: \_\_\_\_\_.

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**RELEASE OF PHI TO SPECIFIED PARTIES**

Do we have permission to release your protected health information to anyone involved in your care?  YES  NO

If "YES", list the **name(s)** of the person(s) who has permission for access to your protected health information. Please do not use general descriptions such as "**family**", or "**friend**". We need name, relationship and phone number. Also, list information they have access to, for example, "entire medical records", "specific dates", "specific types of examination", etc.

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Information \_\_\_\_\_  
Telephone \_\_\_\_\_

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Information \_\_\_\_\_  
Telephone \_\_\_\_\_

**I understand that my permission for the release of my protected health information to parties listed above will remain in effect for three years, unless revoked in writing.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient representative signature if patient unable to sign. \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

**PREFERRED LANGUAGE INFORMATION**

1. What language do you usually speak at home, or consider your primary language? \_\_\_\_\_  
(If English is your answer, skip question #2.)

2. If English is not your primary language, would you say you speak English (circle your answer):  
**Very Well**, **Well**, **Not Well**, or **Not at all?**

**GUARDIANSHIP AND/OR HOSPICE CARE INFORMATION**

Does someone have Power of Attorney or legal guardianship for you?  Yes  No

Are you currently under in-patient or out-patient hospice care?  Yes  No

**If you answered yes, to either of these questions, please provide us with contact information for the guardian and/or the hospice. Shepherd Eye Center also needs a copy of the POA or legal guardianship paperwork if this applies.**

Legal Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Name of Hospice Service Case Manager's Name Telephone Number

**CONSENT TO OBTAIN MEDICATION HISTORY**

A medication history is a list of prescription medicines that our practice providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in our practice electronic medical record system and become part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

**I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. This consent will remain in effect for three years.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature Date

**CULTURAL BACKGROUND INFORMATION**

<i>The Federal Government requires that we ask the following questions of our patients. Providing the information below is voluntary and has no impact on your medical eye care at Shepherd Eye Center. Please fill out Sections 1 AND 2.</i>	
<b>SECTION #1 - ETHNICITY</b> (Please check one box in Section 1. Continue with question Section 2 regardless of your answer in Section 1)	
<input type="checkbox"/> Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin (regardless of race.)
<input type="checkbox"/> Non-Hispanic or Latino	
<b>SECTION #2 – RACE</b> (Please check one box)	
<input type="checkbox"/> American Indian or Alaskan Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
<input type="checkbox"/> Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
<input type="checkbox"/> Other (describe)	
<input type="checkbox"/>	I prefer not to answer these questions.