PATIENT REGISTRATION FORM

Patient Name (Last) (First) (Middle Initial)	Home/Cell phone #	Email address

Patient Address (Mailing) City State Zip	Marital Status S M D W

Gender M F	Birthdate	Birthplace	Maiden Name	SS#	Veteran Y N

Employer (Patient/Parent) Address Occupation	How long	Employer's Phone #

Spouse Name	Birthdate	Employer	Phone #

Notify in case of Emergency (not living with you) Address	Relationship Phone #

Insurance: Responsible Party (Last Name) (First)	Relationship	Birthdate	SS#

Responsible Party Address City State Zip	Phone #

Responsible Party Employer Name Address	Occupation	How long	Employer's Phone

1. Insurance Co.	Name of Insured	Relation to patient:	Policy #	Group #	Eff. Date
2. Insurance Co.	Name of Insured	Relation to patient:	Policy #	Group #	Eff. Date
3. Insurance Co.	Name of Insured	Relation to patient:	Policy #	Group #	Eff. Date

I request that payment of authorized insurance benefits for any services furnished by Crane Eye Care be made either to me or to Timothy B. Crane, M.D., Inc. on my behalf. I authorize the release of any necessary medical information about me to the health care financing administration and its agents for its review to determine benefits payable for the related services.

Financial Agreement

ALL CHARGES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED; THIS WILL ALLOW US TO CONTROL OUR COST AND TO KEEP FEES AT A REASONABLE LEVEL. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient or person responsible for all fees is responsible regardless of insurance coverage. Should the account be referred to an attorney for collection, the undersigned or responsible party shall pay reasonable attorney's fees and collection expense. I have completed this form fully, completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim.

Signature of Patient or Legal Guardian _____ Date _____

Patient Information

Name: _____

DOB: _____

How did you learn about Crane Eye Care?

□ Been here before □ Online □ Radio □ Friend

□ Family Member □ Physician □ Other _____

Lifestyle History:

Occupation: _____

Hobbies/Sports: _____

Do you drive?

□ Yes □ No

Do you have any difficulty driving (eg. glare is bothersome or it's difficult to drive at night)?

□ Yes □ No

Do you wear contact lenses?

□ Yes □ No

If yes, please provide any information about your CLs (eg. brand, power, disposing schedule):

_____

Are you interested in laser vision correction?

□ Yes □ No

Do you know that Crane Eye Care performs LASIK and other vision correction procedures?

□ Yes □ No

Eye History (check all that apply):

□ Cataract □ Glaucoma □ Retinal Problems □ Pterygium

□ Eye Surgery _____ □ Other _____

Family History (check all that apply):

□ Cataract □ Glaucoma □ Retinal problems □ Cancer

□ Diabetes □ Crossed eyes □ Other _____

Review of Systems

Name: _____
DOB: _____

Please check all that apply:

General (constitutional)
____ weight change
____ fever/night sweats
____ appetite change
____ trouble sleeping
____ other _____

Ears, Nose, Throat
____ hearing loss
____ sinus problems
____ sores on lip/mucous membranes
____ infections
____ allergies

Cardiovascular (heart/blood vessels)
____ high blood pressure
How long? _____
____ heart attack/date _____
____ chest pain
____ aneurysm
____ heart murmur
____ irregular heart beat (palpitation)
____ heart valvular problems
____ cardiovascular disease

Lungs (respiratory)
____ asthma/wheezing
____ shortness of breath
____ coughing
____ bronchitis/emphysema
____ TB (tuberculosis)

Gastrointestinal (stomach/intestines/liver)
____ ulcers/pain
____ change in bowel habits/constipation
____ hepatitis/jaundice
____ dietary intolerances
____ gallstones/cholecystectomy

Genitourinary (kidney/bladder/prostate)
____ pain/frequent urination
____ urinary infection/blood/discharge
____ sores/ulcers of penis/vagina
____ prostate problems/surgery
____ kidney problems/dialysis

Psychological
____ depression
____ anxiety/panic attacks
____ other

Musculoskeletal (bones/joints/muscles)
____ arthritis
____ muscle pain
____ osteoporosis
____ muscle twitch/spasms

Integumentary (skin)
____ hives
____ rashes/sensitivities
____ keloid/excessive scarring
____ skin sores/ulcers
____ skin cancer

Neurologic (nervous system)
____ migraines
____ head pain/headaches
____ seizures
____ weakness/numbness/paralysis
____ dizziness/light headedness
____ loss of balance
____ change in gait
____ stroke
____ double vision

Endocrine (gland system)
____ diabetes
How long? _____
Insulin? _____
HgbA1c? _____
____ thyroid

Hematologic/Lymphatic (blood/lymph system)
____ anemia
____ excessive bleeding
____ easy bruising
____ clotting problems
____ lymph glands
____ breast surgery with lymph node dissection

Allergic/immunologic
____ drug allergies
____ hay fever/sneezing/runny nose
____ HIV/AIDS
____ lupus
____ immunosuppression/organ transplant

Other
____ smoke
____ alcohol
____ street drugs or substances

Notice of the Uses and Disclosures of Protected Health Information

This notice deals with the sharing of information from your medical records.
Please read carefully.

This Notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health care plan, such as spouse or children. If you do not understand the terms for this notice, please ask for further explanation.

YOUR RIGHTS

Under federal law, you have the right to:

- Inspect and request copies of your medical records.
- Request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations.
- Request that your health care provider append information to your medical record.
- Receive a notice of your privacy rights by your health plan upon enrollment, annually and when their confidentiality practices are substantially amended.
- Receive an accounting of all our disclosures of your Protected Health Information.
- Obtain a copy of this office's confidentiality practices.

USE OF INFORMATION

This office uses your protected health information to provide you with health care services. Under the law, we may use and disclose your Protected Health Information for a variety of purposes, including:

- *Treatment*: We may disclose your Protected Health Information to another physician to whom we refer you for medical treatment.
- *Health Care Operations*: We may disclose your Protected Health Information to a health plan, managed
- care plan, individual practice association, management services organization or to health care providers, such as laboratories or ambulance
- companies, for purposes of their health care operations.
- *Payment:* We may disclose your Protected Health Information to obtain payments.
- *Reminders and treatment alternatives:* We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and
- services that may be of interest to you.

We may disclose your Protected information without your authorization in the following circumstances:

- For public health activities.
- For reporting victims of abuse, neglect or domestic violence.
- For health oversight activities, such as overseeing government benefit programs.
- In response to judicial or administrative orders, such as subpoenas.
- For law enforcements purposes.
- For certain research purposes.
- To avert a serious threat to the health or safety of an individual or the general public.
- For selected governmental functions, such as national security.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, the doctors and his/her staff may use to disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the doctor and his/her staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the doctor and his/her staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
With this consent, the doctor and his/her staff may speak and release my PHI to my following spouse, family member, relative, friend or parties listed below:

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subjected to redisclosure by the recipient and may no longer be protected by a federal HIPAA Privacy Rule.

This consent covers the period of time from my first visit until I revoke my consent in writing. I release the doctor and staff from all legal responsibility that may arise from this authorization.
By signing this form, I am consenting to the doctor and his/her staff's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read the Notice of the Uses and Disclosures of Protected Health Information. I was informed that I might also obtain a printed copy of the notice from your receptionist. I hereby acknowledge that I viewed a copy of the notice.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient Print Name of Legal Guardian