CREEKSIDE
VISION & HEARING

NEW PATIENT INFORMATION

Date: _____

PLEASE USE BLUE OR BLACK INK ONLY

Patient Name: _____ Birth Date:_____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone#: _____ Social Security#: _____

Cell Phone#: _____ Work Phone#: _____

Preferred Phone# for Reminder Calls (circle one): Home Cell

E-mail Address: _____

Family Doctor: _____

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ African American ☐ Asian ☐ Native American ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Employment Information:

Employer:_____

☐ Full-Time ☐ Part-Time ☐ Retired

Employer Address:_____
(Street) (City) (State) (Zip)

If Self-Employed, type of business:_____

Spouse Information:

Spouse Name:_____ Birth Date:_____

Social Security#:_____ Cell Phone#:_____

Employer: _____

☐ Full-Time ☐ Part-Time ☐ Retired Work Phone#:_____

Emergency Information:

Emergency Contact Name:_____

Phone #:_____ Relationship: _____

IF PATIENT IS A MINOR CHILD, COMPLETE THE FOLLOWING INFORMATION:

Father's Name:_____	Mother's Name:_____
Birth Date:_____	Birth Date: _____
Social Security#:_____	Social Security#:_____
Address:_____	Address:_____
_____	_____
Home Phone:_____	Home Phone:_____
Employer:_____	Employer:_____
Work Phone:_____	Work Phone:_____
E-mail:_____	E-mail:_____

PLEASE CONTINUE ON REVERSE

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INSURANCE INFORMATION

1st Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

2nd Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

3rd Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

Vision Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

Hearing Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

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VISION & HEARING

MEDICAL HISTORY

Name: _____ Date of Birth:_____ Date:_____
Occupation: _____ ☐ Male ☐ Female
Primary Care Physician: _____ Referring Physician: _____

Please list allergies / reactions to medication or food: None ☐

_____

_____

Please list all medication you are currently taking (including eyedrops, over-the-counter medications, vitamins, etc.) None ☐

_____

_____

Have you ever been treated for any medical conditions:

	Yes	No	Comments/Description
High Blood Pressure	☐	☐	_____
Heart Disease or Problems	☐	☐	_____
Allergy or Hay Fever	☐	☐	_____
Asthma or Lung disease	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Other serious / chronic illness	☐	☐	_____

Do any medical or eye diseases run **in your family**? Please list their relationship to you (uncle, sister, etc.)

Diabetes	☐ Yes ☐ No _____	Glaucoma	☐ Yes ☐ No _____
High Blood Pressure	☐ Yes ☐ No _____	Cataracts	☐ Yes ☐ No _____
Allergy	☐ Yes ☐ No _____	Crossed / lazy eyes	☐ Yes ☐ No _____
Asthma	☐ Yes ☐ No _____	Macular Degeneration	☐ Yes ☐ No _____
Cancer	☐ Yes ☐ No _____	Retinal Detachment	☐ Yes ☐ No _____
Bleeding problems	☐ Yes ☐ No _____	Blindness	☐ Yes ☐ No _____

Please list all past surgeries and approximate dates: None ☐

_____

_____

_____

Please list all hospitalizations and approximate dates: None ☐

_____

_____

Tobacco use: ☐ Current ☐ Former ☐ Never How much and for how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

PLEASE CONTINUE ON REVERSE

Do you **currently** have any of the following problems: If yes, circle problem(s) or describe

	Yes	No	If yes, explain:
Fever(s), unexpected weight loss / gain, fatigue	☐	☐	_____
Allergic Problems (*hay fever, sneezing, hives, etc)*	☐	☐	_____
Heart problems (*chest pain, murmurs, irregular heart beat*)	☐	☐	_____
Respiratory problems (*shortness of breath, wheezing, coughing*)	☐	☐	_____
Gastrointestinal problems (*heartburn, abdominal pain, diarrhea, vomiting*)	☐	☐	_____
Urinary problems (*pain or discomfort, blood in urine*)	☐	☐	_____
Skin problems (*rashes, eczema, excessive dryness, acne*)	☐	☐	_____
Musculoskeletal problems (*muscle aches, joint pain, swollen joints)*	☐	☐	_____
Neurologic problems (*numbness, weakness, headaches, paralysis*)	☐	☐	_____
Psychiatric problems (*depression, anxiety*)	☐	☐	_____

For Eye Visits Only

Have you experienced any:	Yes	No		Yes	No
Blurred vision	☐	☐	Do you wear glasses?	☐	☐
Floaters or flashes of light	☐	☐	Do you wear contact lenses?	☐	☐
Redness of eyes	☐	☐	Type: _____		
Irritation or itching of eyes	☐	☐			
Discharge from eyes	☐	☐			

Please list any past or present eye diseases, infections, injuries or surgeries: None ☐

_____

_____

For Hearing Visits Only

Have you experienced any:	Yes	No		Yes	No
Loud noise exposure at work or home	☐	☐	Hearing Loss	☐	☐
Any ringing or buzzing in the ears	☐	☐	Do you wear hearing aids	☐	☐
Have you ever worn a hearing aid	☐	☐			

Comments:

_____

_____

_____

The above was reviewed with the patient: _____ Date:_____

CREEKSIDE
VISION & HEARING

FINANCIAL POLICY

We recognize the need for a definite understanding between patient and physician regarding financial arrangements for medical care. Responding to this need, we have established the following financial policy. Please take a moment to read through the policy, sign it, and return it to this office at the time of your visit. If you have any questions regarding this policy, please do not hesitate to ask us.

You are responsible for your deductible, your co-payment amounts and any services not covered by your insurance. We require that payment for any of these out-of-pocket expenses be made at the time of service. If this is not possible, please make payment arrangements with our billing office before your scheduled appointment.

We participate with many health, vision and hearing plans. When we participate with a benefit plan, we agree to submit claims for the services we provide to our patients, and we agree to accept the "approved amount" as payment in full for the covered services we provided. The approved amount often includes a specific amount that is the responsibility of the patient to pay. The portion that the patient is responsible for is usually referred to as co-payments, deductibles or co-insurance. It is our policy to collect this amount at the time of service.

If you have benefits through a plan we are not contracted with, payment is expected at the time of service. Please remember that your insurance coverage is a contract between you, your employer and your insurance company. We will submit one courtesy claim to a commercial carrier for you, however all charges are your responsibility and will be due at the time of service.

I have read and understand the above Financial Policy.

Signature_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records.

I hereby agree to a transfer of benefits for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to the providers of Creekside Vision & Hearing, P.L.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient/Parent/Guardian Signature_____ Date_____

CREEKSIDE
VISION & HEARING

Understanding Your Health Record and Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. We refer to this information as your medical record. Your medical information is personal. The physician's and staff at Creekside Vision & Hearing, P.L.C. are committed to protecting your medical information. Understanding what is in your record and how your health information is used helps you to ensure its accuracy.

Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, plans for future care, demographics, and health insurance information. We need this information to provide you with quality care and to comply with certain legal requirements. We use this information for planning your care and treatment, to obtain payment for treatment, and for administrative purposes to evaluate the quality of care you receive.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

How This Office May Use and Disclose Your Medical Information

We use and disclose health information about you for treatment, payment, and health care operations. For example, we may use or disclose your health information to other physicians or healthcare providers providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you. We may use and disclose your health information in connection with our healthcare operations such as quality assessment and improvement activities, conducting training programs, accreditation, certification, licensing or credentialing activities.

The following describes the different ways that your medical information may be used or disclosed by our office for situations other then for treatment, payment, or administrative review. Not every possible use or disclosure is specifically mentioned.

Appointment Reminders: We may use and disclose information as a reminder to you that you have an appointment at this office. We currently use methods of phone calls, messages on answering machines, or postcards sent through the mail.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information to someone able to help prevent a serious threat to your health and safety or the health and safety of the public or another person.

Individual Rights

In most cases, you have the right to look at or obtain a copy of your health information. It is our policy to charge a processing fee of $15.00 and an additional .25 cents for each page for copies of your medical record. If you request a copy of your medical record, or to review your medical record, we will respond to your request within 30 days of receipt of your notice.

You have the right to receive information on the instances where we have disclosed health information about you for reasons other than treatment, payment, or administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information except when specifically authorized by you, or when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our Privacy Official or our Administrator. You also may send a written complaint to the U.S. Department of Health and Human Services. The Privacy Official or Administrator can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice and in our policies.

If you have any questions or complaints, please contact:

Privacy Official or Administrator
Creekside Vision & Hearing, P.L.C.
1761 W. M-43 Hwy., Hastings, MI 49058
Phone: (269) 945-3888 fax: (269) 945-2112
Email: Eentinfo@eyeentmds.com

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ACKNOWLEDGEMENT OF RECEIPT

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy, "Understanding Your Health Record and Information" form.

_____ _____
Patient or Guardian Signature Date

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On _____, 20_____, _____ presented this Acknowledgement of Receipt of Notice of Privacy Form to _____ (the "Patient"). The Patient refused to provide a signature when requested.

In an effort to protect your privacy, please indicate how we can release your medical information and to whom.

I give permission for my information to be released via:

☐ Fax
☐ Mail
☐ Phone
☐ Other

I give permission for my medical information to be released to the following individuals:

NAME

☐ Mother ..... _____
☐ Father..... _____
☐ Stepmother…… _____
☐ Stepfather ……..... _____
☐ Grandparents ..... _____
☐ Other Physicians..... _____
☐ Legal Guardian..... _____
☐ Spouse ..... _____
☐ Other..... _____