INNOVATIVE EYECARE

Please list your name & DOB EXACTLY as reflected by your insurance company:

Last Name: First: MI:	Parent Name & phone # (if patient is a minor):
Address:	Employed by:
City, State, Zip:	Occupation:
Home Phone: Cell Phone:	Daytime:
Birthdate: Age: ❑ Male ❑ Female	Preferred Language: ❑ English ❑ French ❑ Japanese ❑ Spanish

Email address (Used for reminder and recall purposes only):

Race:
❑ American Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Pacific Islander ❑ White ❑ Decline to Specify

Ethnicity:
❑ Hispanic or Latino ❑ Pacific Islander ❑ Not Hispanic or Latino ❑ Decline to Specify

Hobbies (if special visual requirements are needed):

Which doctor would you prefer to see? ❑ Dr. McQueen ❑ Dr. Beck ❑ Dr. Collins ❑ Dr.Thai ❑ Dr.Trejo ❑ No Preference

Have you ever been told by a doctor that you have any of the following:

❑ High Blood Pressure	❑ Amblyopia (lazy eye)	❑ Glaucoma
❑ Diabetes	❑ Strabismus	❑ Cataracts
❑ Thyroid Disease	❑ Retinal Disorders	❑ Eye Surgery
❑ Arthritis	❑ Eye Injuries	❑ Other Eye Disease (list below)

❑ Other Medical Conditions (please list): _____

Are you presently taking or recently discontinued any medications, hormones, or birth control pills? (please list)

Are you allergic to any medications or have any other allergies? (please list) _____

Do you currently use any tobacco products ? ❑ Yes ❑ No

Is there history of the following conditions in your immediate family (Parents, siblings, children)?

❑ Age Related Macular Degeneration	❑ Glaucoma	❑ Retinal Disorders
❑ High Blood Pressure	❑ Diabetes	❑ Cataract

❑ Other Medical Conditions or Eye Diseases (please list):

↓ PLEASE SEE BACK SIDE ↴

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Innovative Eyecare make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Innovative Eyecare's Notice of Privacy Practice and agree to continue my care with Innovative Eyecare under said terms.
- ☐ I was given the opportunity to read Innovative Eyecare's Notice of Privacy Practices and declined but wish to continue my care with Innovative Eyecare under the terms of Innovative Eyecare's privacy policies.
- ☐ I have read or had explained to me Innovative Eyecare's Notice of Privacy Practice and do not wish to continue my care with Innovative Eyecare under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care.

❋❋

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____________________________________ __________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

______________________________ _______________________
Representative Relationship to Patient