RUTZEN EYE SPECIALISTS & LASER CENTER

New Patient Registration Form

Printed Name: _____ DOB: _____

Patient Information

Name: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. _____
(First) (Middle) (Last)

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Street Address (or PO Box): _____

City: _____ State: _____ Zip: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Phone: (H) _____-_____-_____ (W) _____-_____-_____ (Cell) _____-_____-_____

Patient Email Address: _____

Preferred Language: ☐ English ☐ Spanish ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Islander
☐ Multiracial ☐ Unknown

Emergency Contact Name: _____ Phone: _____-_____-_____

Relationship to Patient: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

May we leave a message on your home, work, or cell phone regarding appointment reminders? ☐ Yes ☐ No

If you provide an e-mail address, may we communicate with you via e-mail (see below)? ☐ Yes ☐ No

Responsible Party (if above is a minor) ☐ Same as above

Name: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. _____
(First) (Middle) (Last)

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Street Address (or PO Box): _____

City: _____ State: _____ Zip: _____ Phone: (H) _____-_____-_____

Your Physicians

Primary Care Physician: _____ Phone: _____-_____-_____

Most recent visit to Primary Care Physician: Date _____

Referring Physician: _____ Phone: _____-_____-_____

Other Physician: _____ Phone: _____-_____-_____

I certify that the information above is accurate and true and is only to be used for treatment, billing, & insurance processing. I will not hold my physician or any member of Rutzen Eye Specialists (RES) responsible for errors or omissions I have made on this form. I authorize the release of any information, including medical information, to my insurance company to determine my insurance benefits. I may revoke this authorization at any time in writing. I authorize RES to release and/or send medical information about my case to other consulting and/or referring physicians. I agree that regardless of my insurance status, I am responsible for the balance on my account and any charges not covered by my insurance. I understand that without a proper referral or authorization from my insurance, I am responsible for all charges. I also understand that I am responsible for obtaining authorization or referral from my primary care physician. If I give permission for RES to communicate through e-mail, I am aware that e-mail is not considered secure and my patient information could be at risk. I may revoke this permission at any time and request another form of communication that is considered secure, such as fax or mail. If I contact RES via e-mail, I am giving permission to reply via e-mail.

Signature: _____ **Date:** _____ / _____ / _____

Summary Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This is a brief summary of your privacy rights and the privacy practices of Rutzen Eye Specialists and its affiliated facilities. Please also read our FULL Notice of Privacy Practices for a full description of our practices and of your rights. Please review this notice carefully.

Rutzen Eye Specialists, along with your Primary Care Physician, Referring Physician, & all other Physicians / facilities who participate in your care are allowed to share medical information with each other as part of an organized health care arrangement for treatment, payment, and operational activities. We will use this information in order to provide our patients complete & comprehensive health care services. If you have any questions with either our Summary or Full Notice of Privacy Practices, please contact Tanya Kelly, Rutzen Eye Specialists Office Manager at (410) 975-0090.

Our Commitment

We are committed to protecting your Private Health Information. As health care providers, Rutzen Eye Specialists is required by law to keep health information about you private, to give you our Notice about our privacy practices and to follow the practices outlined in our Full Privacy Notice.

How We May Use and Disclose Your Information

We may use your Private Health Information treatment, payment, and health care operations. Under certain circumstances, Rutzen Eye Specialists may also disclose your Private Health Information for other purposes without your written permission. We may give out information about you for public health purposes; to report abuse, neglect, or domestic violence, for health oversight audits or inspections, for certain approved research purposes, for funeral arrangements or organ donations, to government programs, to workers' compensation, and in emergency situations. We may also disclose health information when required by law, such as in response to a request from law enforcement or in response to a court order. We may also contact you for appointment reminders and to tell you about possible treatment options and health services.

Your Rights Concerning Your Health Information

You may ask to review or receive copies of your health information. You may request an accounting of certain disclosures we have made from your records. You may request alternate forms of communications. You may ask us to restrict how we use or disclose your Private Health Information. You may complain to us and to the federal government if you believe your privacy rights have been violated. You have a right to a paper copy of our current Full Privacy Notice.

We reserve the right to make changes to this summary Notice and will make available a current Full Privacy Notice.

Signature: _____ **Date:** _____

I hereby give permission for you to discuss my medical chart along with any other insurance, physician, or billing related inquiries with the persons listed below. If at any time, I wish to remove this permission, I will give written notice to RES.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

RUTZEN EYE SPECIALISTS & LASER CENTER

New Patient Registration Form

Printed Name: _____ DOB: _____

How Did You Learn About Our Practice?

☐ Doctor Referral ☐ Family/Friend ☐ RutzenEye.com ☐ Newspaper
☐ Facebook ☐ Yellow Pages ☐ Insurance Directory ☐ Other _____

Pharmacy Information

Pharmacy Name: _____ City: _____ Phone: _____-_____-_____

Medical Questionnaire

If you are a woman, is there a chance you might be pregnant? ☐ Yes ☐ No

What is your profession?

_____

Do you have any activities with special vision requirements? (pilot, firearms, art, etc.)

_____

Do you wear glasses? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No

Have you had any previous eye problems or eye surgeries?

_____

_____

_____

Do you take any eye drops? ☐ Yes ☐ No

Medication	Which eye? (R, L, both)	How many times/day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any other medications?
☐ Yes ☐ No ☐ See Attached List
(*List names only)*

_____	_____
_____	_____
_____	_____

Do you have allergies to medication? ☐ Yes ☐ No

Medication experienced	*Reaction or problem*
_____	_____
_____	_____
_____	_____

Past Medical History

Do you have any of the following conditions? *(Check those that apply.)* ☐ **NONE**

☐ Diabetes	☐ Stomach ulcers	☐ Oral cold sores	☐ Arthritis (regular/osteo)
☐ High blood pressure	☐ Bowel disease	☐ Genital herpes	☐ Arthritis (rheumatoid)
☐ High cholesterol	☐ Hepatitis	☐ HIV or AIDS	☐ Seizures
☐ Heart disease	☐ Seasonal allergies	☐ Enlarged prostate	☐ Thyroid disease
☐ Stroke	☐ Eczema	☐ Kidney disease	☐ Cancer
☐ Hearing loss	☐ Asthma	☐ Anxiety	Type: _____
☐ Migraines	☐ COPD/Emphysema/ Bronchitis	☐ Depression	☐ Autoimmune

RUTZEN EYE SPECIALISTS & LASER CENTER

New Patient Registration Form

Printed Name: _____ DOB: _____

Family Medical History

Does anyone in your family have any of the following? *(Check those that apply)* ☐ **NONE** ☐ **ADOPTED**

☐ Macular degeneration Relation: _____

☐ Glaucoma Relation: _____

☐ Other eye disease Relation: _____

Current Medical History

Do you smoke? ☐ Yes ☐ No ☐ Formerly

If yes, how many packs per day? _____

How many years did you smoke? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Formerly

If yes, how much? _____

Have you recently experienced any of these symptoms? *(Check those that apply)* ☐ **NONE**

General
☐ fatigue
☐ fevers
☐ weight gain
☐ weight loss

Ear/Nose/Throat
☐ nasal congestion
☐ sinus problems
☐ sore throat

Breathing
☐ cough
☐ shortness of breath
☐ wheezing

Heart
☐ chest pain or pressure
☐ palpitations
☐ leg swelling

Gastrointestinal
☐ abdominal pain
☐ nausea
☐ vomiting

Genital/Urinary
☐ pain with urination
☐ genital sores
☐ blood in the urine

Skin
☐ rashes

Hormonal
☐ cold intolerance
☐ heat intolerance
☐ excessive thirst

Neurological
☐ headaches
☐ dizziness
☐ numbness of extremities

Psychological
☐ depressed mood
☐ nervousness

Musculoskeletal
☐ joint pain
☐ joint swelling
☐ muscle weakness

Blood
☐ easy bleeding
☐ easy bruising

Allergies
☐ seasonal

☐ other _____

☐ other _____

☐ other _____