PLEASANT VALLEY Eyecare

216.642.5500
pleasantvalleyeycare.com

PATIENT INFORMATION

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ M ☐ F

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____ ☐ Glaucoma ☐ Diabetes ☐ Seizure

Primary Phone _____ Daytime Phone _____ Email Address (if we may contact you by email) _____

Occupation _____ Are you a student? ☐ Yes ☐ No

How did you find us? ☐ Insurance ☐ Family ☐ Friend ☐ Close to home/work ☐ Other Who were you referred by? _____

INSURANCE INFORMATION

Information of person responsible for bill: Is this person a patient here? ☐ Yes ☐ No

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address (if different from patient) _____ City _____ State _____ Zip Code _____

Do you have VISION insurance? ☐ Yes ☐ No ☐ Not Sure Insurance Name _____

Do you have MEDICAL insurance? ☐ Yes ☐ No ☐ Not Sure Insurance Name _____

Subscriber Information:

First Name _____ MI _____ Last Name _____ Social Security Number _____

Date of Birth _____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Student ☐ Domestic Partner ☐ Other

Please Read:

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purpose of treatment, payment or health care operations. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.
I acknowledge that I have received and/or read the *Notice of Privacy Practices* from Pleasant Valley Eyecare.

Parent/Guardian Signature _____ Date _____

PLEASANT VALLEY Eyecare

216.642.5500
pleasantvalleyeycare.com

Patient Name _____ Date _____

Patient Medication History

Are you allergic to any medication? ☐ Yes ☐ No If yes, what? _____

Are you taking any medication? ☐ Yes ☐ No

List any medication (or attach list): _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Race	Please indicate your race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unable to Determine or Decline to Answer
Ethnicity	Please indicate your ethnicity: ☐ Other ☐ Hispanic / Latino
Preferred Language	Please indicate your preferred language: ☐ English ☐ Chinese ☐ Spanish ☐ Japanese ☐ French ☐ Italian ☐ Portuguese ☐ Russian ☐ Declined ☐ Unavailable (unknown) ☐ Other (Please specify):
Smoking Status (if over 13)	Please select your current smoking status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker - Please list date range you smoked: _____ to _____ ☐ Never smoked ☐ Smoker, current status unknown ☐ Unknown if ever smoked
Pharmacy you use	**Pharmacy:** **Location:**