

CHART: _____

PORTER OPHTHALMOLOGY

Patient Information

Thank you for choosing our office for your eye care needs.

If you have any questions or need assistance, do not hesitate to ask. We are happy to help.

Date: _____

Patient LEGAL Name: _____
First MI Last

Prefers to be called/goes by: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home () _____ Work () _____ Other () _____

Email Address: _____ Twitter ID: _____

Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Ethnicity: Non-Hispanic Hispanic

Race: African American Asian American Caucasian Native American Other _____

Employment: Retired Student Unemployed Employer _____

Emergency Contact: Name _____ Phone () _____

Relationship to you: Spouse Parent Child Brother/Sister Other _____

Person Responsible for Bill (Required if patient is a minor or leave blank if you are responsible)

Name: _____ Phone: () _____

Address: _____

Relationship to Patient: Parent Legal Guardian Other _____

Insurance Information: Although we will make a copy of your Insurance cards, we will need additional information from you, which is requested below. If you are the subscriber, you do not have to re-list your social security number and date of birth which is listed above - simply write "self" in the name field.

INSURANCE NAME	SUBSCRIBER				
	NAME	SOCIAL SECURITY #	DATE OF BIRTH	SEX	RELATIONSHIP
				M F	
				M F	
				M F	

I authorize the release of my medical and personal information as needed to the above insurance companies to ensure accurate and timely claims processing. I authorize the payments of insurance benefits to Porter Ophthalmology.

I understand that it is MY responsibility to provide current and accurate insurance information. I understand that charges incurred are ultimately my responsibility regardless of the insurance information listed above.

Signature of Patient or Responsible Party

Date

PORTER OPHTHALMOLOGY

Please take a moment to answer the following questions:

What is the primary reason for your visit?

- Interest in refractive surgery (LASIK, SMILE, or PRK)
- Cataracts
- Medical eye problem (glaucoma, injury, infection, etc.)

What were the deciding factors in choosing Porter Ophthalmology?

- Name Recognition
- Location
- Recommendation of Friend
- Online Reviews
- Insurance Participation
- Recommendation of Doctor

Other: _____

Do you have other family members who are patients here? YES NO

If yes, please list their names and relationship to you below:

Name	Relationship
_____	_____
_____	_____

Have you seen our advertisement on any of the following?

- Google ads
- Internet banner ads
- Postcard / Direct Mail
- Other _____

Have you visited our website or any of our social media sites? (Circle all that apply)

eyeporter.com
 facebook.com/eyeporter
 YouTube.com/IsaacPorterMD
twitter.com/eyeporter
 Google+ Porter Ophthalmology
 instagram.com/eyeporter

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Patient's Name: _____

Date of Birth: _____

A copy of our **Notice of Privacy Practices**, effective October 31, 2013 is on display. Under the Health Insurance portability and Accessibility Act (HIPAA), we are required to document that you have been given the opportunity to read the Notice of Privacy Practices. By signing below, you are indicating that you have been given the opportunity to read this document.

Signature: _____

Date: _____

If the signature is not that of the Patient, indicate the relationship of the person signing for the patient (e.g. Parent, Guardian, etc.): _____

If you want a copy to keep for your records, you may print a copy of this document from our website at www.eyeporter.com or you may ask the receptionist for a printed copy.

<p>For Office Use Only</p> <p>If patient or patient's representative does not sign, indicate the reason(s) why signature could not be obtained</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Staff Member Name: _____</p> <p>Date: _____</p>

PORTER OPHTHALMOLOGY RALEIGH, NC

Name: _____ Date: _____ DOB: _____

Have you ever been diagnosed with any of the following?

	none	both	left	right
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any eye injuries/ Other:	_____			

Past Medical History

Please list any major surgery or recent hospitalizations:

Please list any illness that requires you to take medication on a daily basis:

Are you being treated by an eye specialist? doctor and reason:

Have you ever had eye surgery?

Please list which eye, doctor, & date.

LASIK/PRK _____

Cataract surgery _____

Glaucoma _____

Strabismus/Muscle _____

Retina detachment repair _____

Corneal transplant _____

Ptosis/eyelid _____

Other: _____

Do any eye diseases run in your family?

	F	M	SIB	GP
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____			

Do any of these diseases run in your family?

	F	M	SIB	GP
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Social: Tobacco use Y N Alcohol use Y N

Occupation _____

Primary care physician

Name _____

Phone _____

Address _____

Primary eye doctor

Name _____

Phone _____

Address _____

