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: _____________ Social Security Number: ____________________

Address: ____

City: _________________________ State: ___________________ Zip Code: _______________________

Phone: Home ( ) ______________ Work ( ) _______________Other ( ) ________________

Email Address: ____

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 ___________________________

<u>**Insurance Information:**</u> 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 <u>insurance companies</u> 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 (injury, infection, cloudy vision after cataract surgery, 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

☐ Facebook ads ☐ 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 Porter Ophthalmology on Google 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.

For Office Use Only

If patient or patient's representative does not sign, indicate the reason(s) why signature could not be obtained

____

____

____

Staff Member Name: ____

Date: ____

PORTER OPHTHALMOLOGY
RALEIGH, NC

Name: ______________________________ Date: _____________________ DOB: ___________________

Have you ever been diagnosed with any of the following?

	none	both	left	right
Lazy Eye	☐	☐	☐	☐
Cataract	☐	☐	☐	☐
Diabetic Retinopathy	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Iritis	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐

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	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐

Other: ____________________________________
____

Do any of these diseases run in your family?

	F	M	SIB	GP
Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐

Other: _______________________________________
____

Social: Tobacco use Y ☐ N ☐ Alcohol use Y ☐ N ☐
Occupation ___________________________________

Primary care physician
Name ____
Phone ____
Address ______________________________________

Primary eye doctor
Name____
Phone____
Address______________________________________

PORTER OPHTHALMOLOGY

Name: ________________________________ Date: __________________ DOB:_______________________

ARE YOU ALLERGIC TO ANY DRUGS? ____

____

Please list any medications you are currently taking:

MEDICATIONS / DOSAGE/ QUANTITY

Please list any medication you are taking for your eyes: (any eye drops)

MEDICATIONS	CURRENTLY TAKING	DISCONTINUED
	DATE	DATE