ADVANCED EYECARE
Experienced people with vision

NEW PATIENT REGISTRATION PACKET

Preferred Pharmacy: _____ **Primary Care Provider:** _____

Last Name First MI	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	**Is this your legal name? If not, what is?** ☐ Yes ☐ No _____		
Mailing Address	Physical Address (if different)	City	State	Zip
Preferred Phone # (__ __ __) __ __ __-__ __ __ __	Alternative Phone # (__ __ __) __ __ __-__ __ __ __	**Marital Status** (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Union		
Date of Birth __ __/__ __/__ __ __ __	Occupation	Employer		

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient	Phone Number

PRIMARY INSURANCE INFORMATION

☐ I currently have medical insurance ☐ I currently do not have medical insurance

Medical Insurance Name	Policy Number	Group Number
Policy Holder's Name	Policy Holders Date of Birth __ __/__ __/__ __ __ __	Policy Holder's Employer

SECONDARY INSURANCE INFORMATION

☐ I currently have secondary medical insurance ☐ I currently do not have secondary medical insurance

Medical Insurance Name	Policy Number	Group Number
Policy Holder's Name	Policy Holders Date of Birth __ __/__ __/__ __ __ __	Policy Holder's Employer

ADDITIONAL INFORMATION

Race ☐ African American/Black ☐ Multi-Racial ☐ Asian-American ☐ Caucasian/White ☐ Native American ☐ Other_____	**Primary Language if not English:** _____
What is your current gender identity? ☐ Male ☐ Female ☐ MTF Transgender ☐ FTM Transgender ☐ Other ☐ Choose not to disclose	**What is your preferred name?** _____
Have you received the Pneumonia Vaccine? ☐ Yes ☐ No **Do you have a Living Will?** ☐ Yes ☐ No	

322 Dewey Street
Bennington, VT 05201
Phone: (802) 447-8700
Fax: (802) 447-1500

5222 Main Street
Manchester Ctr., VT 05255
Phone: (802) 366-8050
Fax: (802) 366-8045

Doctors Building, Suite 110
North Adams, MA 01247
Phone: (413) 664-6736
Fax: (413) 664-7349

PERSONAL MEDICAL HISTORY

Conditions I have (check all that apply)

☐ Asthma ☐ Cancer ☐ Depression ☐ Diabetes ☐ Emphysema/COPD ☐ Heart Disease ☐ High Blood Pressure
☐ Skin ☐ AIDS/HIV ☐ Lymphatic ☐ Arthritis ☐ Other: _____

Medications-Please fill out or attach list
(Include all prescriptions, over the counter, vitamins, minerals, supplements and herbal products)

Name of Medicine	Dose	Times per day

☐ **No Current Medications**

Allergies and adverse food / drug reactions

Food, Drug or Substance	Side effect / Reaction

☐ **No Known Allergies**

Briefly list all hospitalizations, major illnesses, and injuries, surgeries, and dates:

_____

_____

_____

Family History: Has any blood relative had any of the following? If yes, indicate the relationship to patient.

Blindness.....	☐No ☐Yes	_____	High blood pressure...	☐No ☐Yes	_____
Cataract.....	☐No ☐Yes	_____	Heart disease/stroke...	☐No ☐Yes	_____
Glaucoma.....	☐No ☐Yes	_____	Cancer.....	☐No ☐Yes	_____
Macular Degeneration.	☐No ☐Yes	_____	Arthritis.....	☐No ☐Yes	_____
Retinal Detachment....	☐No ☐Yes	_____	Diabetes.....	☐No ☐Yes	_____

Have you ever had any of the following eye conditions? If yes, please explain.

Eye disease..... ☐No ☐Yes _____
Eye injury..... ☐No ☐Yes _____
Eye surgery/Lasik..... ☐No ☐Yes _____

Do you wear contacts..... ☐No ☐Yes Type: ☐ Daily Wear ☐ Extended Wear

What kind, power and base curve? _____

Do you wear eyeglasses..... ☐ No ☐ Yes Type: ☐ Distance ☐ Read ☐ Bifocals/Progressive

Do you smoke or use other tobacco products:
☐ Yes ☐ No ☐ In the past

Do you drink alcohol:
☐ Yes ☐ No ☐ In the past

To the best of my knowledge, the preceding answers are true and correct:

_____ _____
Patient Signature Date

_____
Printed

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PERMISSION TO RELEASE PATIENT INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we will not give that information out unless their name is provided for our records. Please initial the options you choose.

- Option1: _____ (Initial) I hereby give permission to Advanced Eyecare, PC. to release the selected information about me to those listed below should they call or come into inquire.

(Please check all that apply)

☐ Medical Test Results ☐ Medications ☐ Appointments

☐ Other: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

- Option 2: _____ (Initial) I do not consent to release information about me to others.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

Advanced Eyecare, P.C. is committed to protecting your personal health information in compliance with the law. In summary, Advanced Eyecare, P.C. Notice of Privacy Practices includes:

- Our obligation under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your right relating to your personal health information
- Our right to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in the document
- The person to contact for further information about our Privacy Practices

We are required by law to give you a copy of this notice and obtain your written acknowledgment that you have been made aware of the notice.

_____ _____ _____

Name of Patient (please print) Date of Birth Parent/Guardian (Please print)

_____ _____

Signature of Patient or Parent/Guardian Date

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Erik W. Niemi, DO
Estela V. Ogiste, MD, PhD
Michael Porter,OD
Paula LaRoche, OD
Heidi H. Welnak, OD

PATIENT RESPONSIBILITY

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office with both my Medicare ID card and my secondary ID card if applicable. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke the Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. AEC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name	Patient or Guardian Signature	Date

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