



HOSPITALITY EYECARE
 CENTER of OPTOMETRY

ph 909 383 5000
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164 W Hospitality Lane, Suite 7
 San Bernardino, CA 92408

www.SeeToLive.com

EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE
Patient _____ Date _____ Address _____	Who is responsible for this account? _____ Relationship to Patient _____ Insurance Co. _____ Group # _____
City _____ State _____ Zip _____	Is patient covered by additional Insurance? [] Yes [] No
Email _____ Sex: [] M [] F Age _____ Birthdate _____	Subscriber Name _____ Birthdate _____ SS# _____
Patient SS# _____	Relationship to Patient _____ Insurance Co. _____
Occupation _____	Group # _____
Employer _____	ASSIGNMENT AND RELEASE
Employer Phone # _____	I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Hospitality Eyecare Center all insurance
Employer Address _____	benefits, if any, otherwise payable to me for services rendered. I understand that I am
Spouse's Name _____	financially responsible for all charges whether or not paid by insurance. I hereby authorize
Birthdate _____ SS# _____	the doctor to release all information necessary to secure the payment of benefits. I authorize
Occupation _____ Spouse's Employer _____ Whom may we thank for referring you? _____	the use of this signature on all insurance submissions. Responsible Party Signature _____ Relationship _____ Date _____

PHONE NUMBERS	
Home _____ Work _____	Ext. _____ Spouse's Work _____
Best time and place to reach you _____	
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)	
Name _____	Relationship _____
Home Phone _____	Work Phone _____

MEDICATIONS	ALLERGIES
List medications you are currently taking, including eye drops, over the counter medications & herbs: _____ _____ _____ Pharmacy Name _____ Phone _____	List your allergies to medication or other substances: _____ _____ _____ _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	[] Yes [] No	[] Yes [] No	Hepatitis (Type _____)	[] Yes [] No	[] Yes [] No
Arthritis	[] Yes [] No	[] Yes [] No	High Blood Pressure	[] Yes [] No	[] Yes [] No
Artificial Heart Valve	[] Yes [] No	[] Yes [] No	Kidney Disease	[] Yes [] No	[] Yes [] No
Artificial Joints	[] Yes [] No	[] Yes [] No	Lazy Eye	[] Yes [] No	[] Yes [] No
Asthma	[] Yes [] No	[] Yes [] No	Lupus	[] Yes [] No	[] Yes [] No
Bleeding	[] Yes [] No	[] Yes [] No	Migraine Headaches	[] Yes [] No	[] Yes [] No
Blindness	[] Yes [] No	[] Yes [] No	Pacemaker	[] Yes [] No	[] Yes [] No
Cancer	[] Yes [] No	[] Yes [] No	Poor Color Vision	[] Yes [] No	[] Yes [] No
Cataracts	[] Yes [] No	[] Yes [] No	Retinal Disease	[] Yes [] No	[] Yes [] No
Chemical Dependency	[] Yes [] No	[] Yes [] No	Rheumatic Fever	[] Yes [] No	[] Yes [] No
Diabetes	[] Yes [] No	[] Yes [] No	Shingles	[] Yes [] No	[] Yes [] No
Drug Sensitivity	[] Yes [] No	[] Yes [] No	Skin Conditions	[] Yes [] No	[] Yes [] No
Emphysema	[] Yes [] No	[] Yes [] No	Stroke	[] Yes [] No	[] Yes [] No
Epilepsy	[] Yes [] No	[] Yes [] No	Thyroid Conditions	[] Yes [] No	[] Yes [] No
Eye Surgery	[] Yes [] No	[] Yes [] No	Tuberculosis	[] Yes [] No	[] Yes [] No
Glaucoma	[] Yes [] No	[] Yes [] No	Turned Eye	[] Yes [] No	[] Yes [] No
Hay Fever	[] Yes [] No	[] Yes [] No	Are you pregnant? _____	Number of Children _____	
Heart Condition	[] Yes [] No	[] Yes [] No	Tobacco use _____	Alcohol use _____	

EYE HEALTH HISTORY: experiencing any of the following?

Place a Mark on "Yes" or "No" to indicate if you have had any of the following:

	Bloodshot Eyes	[] Yes [] No	Floaters or Spots	[] Yes [] No
	Blurred Vision - Distance	[] Yes [] No	Glaucoma	[] Yes [] No
	Blurred Vision - Near	[] Yes [] No	Headaches	[] Yes [] No
Do you use a computer	Burning Eyes	[] Yes [] No	Itching Eyes	[] Yes [] No
more than 30 minutes a day?	Cataracts	[] Yes [] No	Light Sensitivity	[] Yes [] No
	Poor Color Vision	[] Yes [] No	Loss of Vision	[] Yes [] No
Do you wear sunglasses	Crossed Eyes	[] Yes [] No	Migraine Headaches	[] Yes [] No
with UV protection?	Discharge from Eyes	[] Yes [] No	Poor Night Vision	[] Yes [] No
	Dizzy Spells	[] Yes [] No	Red Eyes	[] Yes [] No
Are you interested in	Double Vision	[] Yes [] No	Seeing Halos	[] Yes [] No
Contact Lenses?	Dry Eyes	[] Yes [] No	Seeing Flashes	[] Yes [] No
	Eye infection	[] Yes [] No	Temporary Loss of Vision	[] Yes [] No
Are you interested in Lasik?	Eye injury	[] Yes [] No	Twitching Eyelid	[] Yes [] No

Thank you for providing this information. It helps me provide optimal eye health and vision care for you!

Dr. Cynthia Corbett



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PATIENT ACKNOWLEDGMENT

Acknowledgment Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of this entity. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We strongly encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site at www.SeeToLive.com or contacting our office at:

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909.383.5000

Info@SeeToLive.com

Signature of patient/legal representative: _____

Date/Time: _____

INABILITY TO OBTAIN PATIENT ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from obtaining acknowledgment, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Patient incapacitated/ unable to sign
- Other (Please specify)

Patient Name: _____

Patient social security number _____

Signature of Facility Representative: _____

Date/Time: _____