

Patient Information	Patient Last Name		First Name		Middle Name		Maiden Name			
	Address (Street or Box)				City		State	Zip Code		
	Home Phone Number		Cell Phone Number			Work Phone Number		E-Mail		
	Social Security Number		Date of Birth	Assigned Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other: Please specify: _____				
	Gender Identity (Check One) <input type="checkbox"/> Identify as Male <input type="checkbox"/> Identify as Female <input type="checkbox"/> Gender Nonconforming/Non-binary <input type="checkbox"/> Other (Please specify) _____ <input type="checkbox"/> Choose not to disclose				Sexual Orientation (Check One) <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please describe _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose					
	Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown				Race (Check One) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other _____					
	Ethnicity (Check One) <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino				Employer Name		Employer Address			
	Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, Name of Facility		City:			
							Phone Number:			
	Primary Care Physician Name				Phone Number					
Emergency Contact & Relationship			Phone Number		Referring Physician Name		Phone Number			
Complete this section ONLY if Patient is a minor or has a Legal Guardian										
Responsible Party	Responsible Party Last Name		First Name		Middle Name		E-Mail:			
	Address (Street or PO Box)				City		State	Zip Code		
	Home Phone Number		Cell Phone Number			Work Phone Number				
	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other (specify)		Date of Birth		Social Security Number					
Insurance and Subscriber Information	PRIMARY Insurance Company			Effective Date		SECONDARY Insurance Company			Effective Date	
	Claims Mailing Address (Street or PO Box)					Claims Mailing Address (Street or PO Box)				
	City		State	Zip Code		City		State	Zip Code	
	Policy ID Number		Group ID Number			Policy ID Number		Group ID Number		
	Subscriber Name (Policy Holder)		Date of Birth			Subscriber Name (Policy Holder)		Date of Birth		
	Subscriber Social Security Number		Relationship to Patient			Subscriber Social Security Number		Relationship to Patient		
	Subscriber Employer		Work Phone Number			Subscriber Employer		Work Phone Number		
	Subscriber Employer Address (Street or PO Box)					Subscriber Employer Address (Street or PO Box)				
	City		State	Zip Code		City		State	Zip Code	
	Pharmacy	Preferred Pharmacy Name			Pharmacy Address			Pharmacy Phone Number		
Mail-Order Pharmacy Name			Pharmacy Address			Pharmacy Phone Number				

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat and Financial Responsibility

Consent to Treat SECC_NP_F101

I hereby authorize employees and agents of The Retina Group of Washington, PLLC ("RGW") dba Schefkind Eye Care, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility SECC_NP_F102

I hereby authorize The Retina Group of Washington, PLLC ("RGW") dba Schefkind Eye Care, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to RGW for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to RGW. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to RGW.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Preferred Method of Communication SECC_NP_F104

Yes, I want The Retina Group of Washington, PLLC ("RGW") dba Schefkind Eye Care, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my **medical conditions and/or appointment information** is indicated below:

Home Phone Cell Phone Email Mailed Letter Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

- Leave a message with detailed information.
- Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Approved HIPAA Contacts SECC_NP_F105

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that The Retina Group of Washington, PLLC ("RGW") dba Schefkind Eye Care, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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Billing Account Information **Medical Condition Information** **Emergency Contact**

Additional Notes: _____

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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Billing Account Information **Medical Condition Information** **Emergency Contact**

Additional Notes: _____

Notice of Privacy Practices and Acknowledgement of Receipt

SECC_NP_F107

Notice of Privacy Practices and Acknowledgement of Receipt

Patient Name: _____

Date: ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Retina Group of Washington, PLLC (“RGW”) dba Schefkind Eye Care, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. “Protected Health Information” is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____ I, _____, received a copy of this office’s Notice of Privacy Practices.
(Today’s Date) (Patient’s Name)

Please Print Name

Signature

Date

* Schefkind Eye Care’s Notice of Privacy Practices can also be found on our website: <https://www.schefkindeyecare.com>

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This Acknowledgement Form will become part of your permanent medical record.

Medical Questionnaire / Eye History
SECC NP F108

Patient's Name:		Date / /	
What ocular problem brings you in?			
When was your last eye exam?	/ /	Eye Doctor	
What did your doctor tell you?			

YES NO			
Do you wear glasses for vision?			
Do you wear contact lenses?		If so, last time they were changed?	
Do you have Glaucoma?		If so, how is it being treated?	
Have you had cataract surgery?		If so, Which Eye?	Date of Surgery Name of Surgeon
		Left Eye	/ /
		Right Eye	/ /
Have you had other surgery? <i>Please list details below</i>			

Medical History – Social History

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List ALL Medications that you are presently taking, including any eye drops:

_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL Allergies Including Medications:

FAMILY HISTORY

Is there a family history of	YES	NO	Relative:
Cataracts?			
Glaucoma?			
Retinal Disease?			
Diabetes?			
Hypertension?			
Anemia?			
Other Eye or Systemic Disease?			

Medical History Questionnaire / Review of Symptoms

SECC_NP_F109

Patient's Name:	Date / /
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Do you have any problems in the following areas? *Please check all applicable*

		YES	NO			YES	NO
GENERAL				GI / GU			
Fever				Vomiting			
Fatigue				Bloody Bowel Movement			
Weight Loss / Gain				Heartburn			
Frequent Colds				Loss of Appetite			
EYES				Difficulty with Urination			
Blurred Vision				Blood in Urine			
Double Vision				Frequent Urination			
Redness				Pain in Urination			
Sandy or Gritty Feeling				MUSCULOSKELETAL			
Blind Spots				Muscle Pain			
Floater				Joint Pain, Arthritis			
Flashes				INTEGUMENTARY			
Lazy Eye				Rash, Bruise Easily			
Itching / Burning				Breast Disease			
Excess Tearing				NEUROLOGICAL			
Glare / Light Sensitivity				Fainting, Frequent Headaches			
Eye Pain				Seizures			
Chronic Infection Eye / Lid				PSYCHIATRIC			
ENT: Ears, Nose & Throat				Depression			
Sinus Infection				Anxiety			
Cough				Psychiatric Problems			
Trouble Walking				ENDOCRINE			
Hoarseness				Excessive Thirst			
Loss of Hearing				Excessive Sweating			
Nose Bleeds				HEMATOLOGIC / LYMPHATIC			
HEART				Swollen Glands			
Chest Pain				ALLERGIC / IMMUNOLOGIC			
Irregular Heart Beat				Seasonal Allergies			
Pacemaker				Hay Fever			
Heart Murmur				OTHER			
Swollen Feet / Ankles				Pregnant			
Leg Cramps when Walking				Menopausal			
LUNGS				Vaginal Bleeding			
Wheezing, Shortness of Breath				Breast Lumps			
Coughing up Blood / Phlegm							
COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)							