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 (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 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.

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