Dr. Hanlen and Associates
Eyes on the Diamond   www.drhanlen.com
104 W. Main St.
Boalsburg, PA 16827

PATIENT REGISTRATION

Please print and complete form and bring with you to your appointment. Completing this form ahead of time will save you time during your visit and help us to be prepared for your appointment. .

PATIENT INFORMATION

Please circle one: Mr. Mrs. Ms. Miss Dr.

First Name:___________________________ Last Name:_____________________ Middle Initial:________

Address, City, State, Zip: ____

Home Phone: ________________ Work Phone: _________________ Cell Phone: _____________________

Sex: Male Female Marital Status: Single Married Divorce Widowed Other

Birth Date: ______________ SS#: ____________________ E-Mail __________________________________

Do you wear glasses? ____Yes ____No Do you wear contact lenses? ____ Yes ____ No

EMPLOYMENT INFORMATION

Employment: ____Full-Time ____ Part-Time ____ Retired

Employer Name: __________________________________

Employer Location: ________________________________

Occupation: _____________________________________

FAMILY DOCTOR/PHARMACY

Physician Name:___________________

Preferred Pharmacy: ________________

RESPONSIBLE PARTY (IF DIFFERENT)

First Name:___________________________ Last Name:_________________________ Middle Initial:_____

Address, City, State, Zip: ____

Home Phone: ________________Work Phone: __________________Cell Phone: _____________________

Sex: Male Female Marital Status: Single Married Separate Divorce Widowed

Birth Date: ______________ SS#: ___________________ E-Mail __________________________________

FAMILY HISTORY

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions

	Relation to You		**Relation to You**
Blindness	____________________________	Diabetes	__________________________________
Cataract	____________________________	Heart Disease	______________________________
Glaucoma	____________________________	High Blood Pressure	________________________
Macular Degeneration	__________________	Thyroid Disease	____________________________
Lazy Eye	_____________________________	Arthritis	__________________________________

*** Please complete Page 2***

Please bring a list of any medications and/or supplements

Bring all insurance cards with you

PRIMARY INSURANCE INFORMATION

Name of insured (First, Last) ___________________________ Relationship to Patient: ___Self ___Spouse

Insured Social Security # ______________________________ _____ Father _____ Mother _____ Child

Insurance Company: ____

SECONDARY INSURANCE INFORMATION

Name of insured (First, Last) ___________________________ Relationship to Patient: ___Self ___Spouse

Insured Social Security # ______________________________ _____ Father _____ Mother _____ Child

Insurance Company: ____

VISION INSURANCE INFORMATION

Name of insured (First, Last) ___________________________ Relationship to Patient: ___Self ___Spouse

Insured Social Security # ______________________________ _____ Father _____ Mother _____ Child

Insurance Company: ____

PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be use to:

** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
** Obtain payment from third-party payers.
** Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Medicare and other medical insurances may reimburse for Optometric eye examinations under certain circumstances. Some insurances do not cover the “refraction” part of the eye examination, which determines the prescription for eyeglasses. However, most insurances cover the major costs for your eye health examination if there is a medical diagnosis. The patient is responsible for any co-payments and/or deductibles. The law requires us to keep your signature on file in order to process all necessary forms in your behalf.

Patient signature: ____ **Date:** _____________________