NEW EYES

Patient Name: _____ Date of Birth: _____

PATIENT CONTACT

New Eyes may contact you regarding appointments, test results, financial matters/billing concerns by telephone at any number associated with your account and leave a message, as necessary. This can include wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails if an email is provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing system if applicable.
My **PREFERRED METHOD OF CONTACT IS**:

Voice Call ☐ Text Message/SMS ☐ Email: _____ Other: _____

New Eyes reminds our patients of their appointments by phone call, text message, and email.

RELEASE OF PHI TO SPECIFIED PARTIES

Do we have permission to release your protected health information to anyone involved in your care? ☐ YES ☐ NO

If "YES," list the name(s) of the person(s) who has permission for access to your protected health information. We need the name, relationship, phone number, and type of access:

Name		Name	
Relationship		Relationship	
Telephone		Telephone	
Information	All Records ☐ or	Information	All Records ☐ or

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely, unless revoked in writing

Print Patient Name	Patient/Parent/Guardian ***Signature***	Date Signed

Patient representative signature if patient is unable to sign:

Signature	Relationship	Date

CONSENT TO OBTAIN MEDICATION HISTORY

A Medication history is a list of prescription medicines that our practice providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this. The collected information is stored in our practice electronic medical records and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications to ensure that your medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might t not include drugs purchased with using your health insurance. Also, over the counter drugs, supplements, or herbal remedies that patients take on their own may not be included.
I give my permission to allow my healthcare provider to obtain medication history form my pharmacy, my health plans, and my other healthcare providers. This consent will remain in effect for three years.

Print Patient/Parent/Guardian	Patient/Parent/Guardian Signature	Date Signed

CULTURAL BACKGROUND INFORMATION AND PREFERRED LANGUAGE

The Federal Government requires that we ask the following questions to our patients. This is voluntary and has no impact on your medical eye care.

ETHNICITY (Check One)	☐ Hispanic or Latino	☐ Non-Hispanic or Latino	
RACE (Check One)	☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ I prefer not to answer	☐ Asian ☐ White	☐ Black or African American ☐ Other
LANGUAGE	☐ ENGLISH	☐ SPANISH	☐ OTHER

If English is NOT your primary language, would you say you speak English: ☐ **Very Well** ☐ **Well** ☐ **Not Well**