# Patient Sign In Sheet

Date: ____________________

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

**Patient Details**

Last Name: ____________________

First Name: ____________________

MI: ____________________

Gender: ☐ Male ☐ Female ☐ Unknown

Date of Birth: ____________________

SSN: ____________________

Suffix: ____________________

Preferred Name: ____________________

Marital Status: ☐ Married ☐ Single ☐ Other

Employment Status: ____________________

Occupation: ____________________

Preferred Language: ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Race: ☐ White ☐ Black / African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Specify

Sexual Orientation ____________________

Gender Identity ____________________

**Address & Insurance**

Primary Addr. ____________________

City: ____________________

State: ____________________

Zip Code: ____________________

Email: ____________________

Phone: ____________________ ☐ C ☐ H

Phone (2): ____________________ ☐ C ☐ H

Preferred Method of Communication: ☐ Email ☐ Text ☐ Phone

Primary Insurance Name: ____________________

☐ Medical ☐ Vision

Insured ID: ____________________

Member ID/Policy # ____________________

Group # ____________________

Primary Member Name: ____________________

Date of Birth: ____________________

Last 4 of SSN: ____________________

Secondary Insurance Name: ____________________

☐ Medical ☐ Vision

Insured ID: ____________________

Member ID/Policy # ____________________

Group # ____________________

Primary Member Name: ____________________

Date of Birth: ____________________

Last 4 of SSN: ____________________

Emergency Contact Name: ____________________

Phone: ____________________

Relation: ____________________

# Patient Sign In Sheet

Date: ____________________

## Do you or a family member have a history of the following eye problems?

*Check all that apply*

| | Self | Family |
|---|---|---|
| Blindness | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Corneal Problems | ☐ | ☐ |
| Diabetic Retinopathy | ☐ | ☐ |
| Dry Eye | ☐ | ☐ |
| Eye Allergy | ☐ | ☐ |
| Eye Injury | ☐ | ☐ |
| Floaters / Spots / Light Flashes | ☐ | ☐ |
| Frequent Eye Infections / Styes | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Glaucoma Suspect | ☐ | ☐ |
| Iritis / Uveitis | ☐ | ☐ |
| Lazy / Crossed Eye | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Retinal Detachment / Tear / Disease | ☐ | ☐ |

Other (describe): ____________________

## Do you or a family member have a history of the following eye surgeries?

*Check all that apply*

| | Self | Family |
|---|---|---|
| Cataract | ☐ | ☐ |
| Corneal Transplant | ☐ | ☐ |
| Eye Muscle Surgery | ☐ | ☐ |
| Glaucoma Laser | ☐ | ☐ |
| Glaucoma Surgery | ☐ | ☐ |
| Lasik / PRK | ☐ | ☐ |
| Retinal Laser | ☐ | ☐ |
| Retinal Surgery | ☐ | ☐ |
| Retinal Injections | ☐ | ☐ |
| RK Incisions | ☐ | ☐ |
| Yag (Laser After Cataract) | ☐ | ☐ |

Other (describe): ____________________

## Do you have a history of the following medical issues?

*Check all that apply*

- Asthma ☐
- Blood Pressure Problems ☐
- Breast Cancer ☐
- Colon Cancer ☐
- Lung Cancer ☐
- Ovarian Cancer ☐
- Prostate Cancer ☐
- Uterine Cancer ☐
- Other Cancer ☐
- Cholesterol Problems ☐
- Depression ☐
- Diabetes or High Blood Sugar ☐
- Emphysema ☐
- Heart Problems ☐
- Kidney Disease ☐
- Liver Disease ☐
- Osteoporosis ☐
- Seizures ☐
- Strokes ☐
- Thyroid Problems ☐
- Surgery ☐
- Allergies ☐

Other (describe): ____________________

## Do you currently use or have any of the following?

*Check all that apply*

- Use Tobacco? ☐
- Use Alcohol? ☐
- Use Drugs Recreationally? ☐
- Have a STD? ☐

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Date: ____________

**Do you have problems with any of the systems below?**

*Check all that apply*

- Allergy / Immunologic (*e.g. Hives, Eczema, Rash, Lumps*) ☐
- Cardiovascular (*e.g. Chest Pain, Palpitations, Labored Breathing*) ☐
- Constitutional (*e.g. Fever, Chills, Weight Change*) ☐
- Endocrine (*e.g. Heat/Cold Intolerance, Frequent Urination, Thirst*) ☐
- Gastrointestinal (*e.g. Heartburn, Nausea, Constipation/Diarrhea*) ☐
- Genitourinary (*e.g. Burning, Pain, Sexual Function, Nocturia*) ☐
- Ears / Nose / Throat / Mouth (*e.g. Hearing, Discharge, Dryness*) ☐
- Hematologic / Lymphatic (*e.g. Bruising, Bleeding, Anemia*) ☐
- Integumentary (*e.g. Moles, Non-healing Lesions, Color Changes*) ☐
- Musculoskeletal (*e.g. Muscle/Joint Pain, Stiffness, Swelling*) ☐
- Neurological (*e.g. Dizziness, Fainting, Seizures, Weakness*) ☐
- Psychiatric (*e.g. Nervousness, Depression, Memory Loss, Stress*) ☐
- Respiratory (*e.g. Cough, Sputum, Wheezing, Shortness of Breath*) ☐

## Personal Eye Information

**Reason(s) for Visit** ☐ Eye Exam ☐ Initial Contact Lens Fitting ☐ Contact Lens Update ☐ Medical Issue

A) Do you wear prescription glasses? *(If no skip to Section B)* ☐ Yes ☐ No

1. How many hours per day do you wear your glasses? ☐ 0-4 ☐ 4-8 ☐ 8+
2. What condition are your current eyeglasses in?
   - ☐ They are in great shape!
   - ☐ A little scratched and worn.
   - ☐ Terrible... I'm hard on my eyeglasses.
3. Do you wear different glasses for different activities? ☐ Yes ☐ No
4. Do you want your lenses to reduce reflections and add greater clarity? ☐ Yes ☐ No
5. Do you want your lenses to have enhanced scratch protection? ☐ Yes ☐ No
6. Do you want your lenses to be easier to clean? ☐ Yes ☐ No
7. Do you want everyday protection from UV light?
   - ☐ Yes, I want the highest level on my lenses (E-SPF 25)
   - ☐ Yes, I want standard protection on my lenses (E-SPF 10)
   - ☐ This is not important to me.

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8. Do your eyes get tired from computer or screen use? ☐ Yes ☐ No

9. Do you prefer to switch your eyeglasses for prescription sunglasses when you go outside or do you want your lenses to darken automatically?

   ☐ I like to have a separate pair of prescription sunglasses.

   ☐ I am interested in lenses that automatically darken.

10. Do you want your lenses to be extra thin and lightweight? ☐ Yes ☐ No

B) Do you wear contact lenses? *(If no skip to Section C)* ☐ Yes ☐ No

1. Do you occasionally sleep with your contact lenses? ☐ Yes ☐ No
2. Do you have back up glasses with a current prescription? ☐ Yes ☐ No
3. Do you have polarized sunglasses? ☐ Yes ☐ No

C) Do you wear non-prescription reading glasses? ☐ Yes ☐ No

D) Do you wear safety glasses? ☐ Yes ☐ No

E) Do you wear sunglasses when outdoors? ☐ Yes ☐ No



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# Notice of Privacy Practices Acknowledgement

## Riverton Family EYE Care

Focused on you and your family

Jodie J. Johnson, O.D.
2998 West 12600 South
Riverton, Utah 84065

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 used 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/eye care professional certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out 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.

Patient Name: ____________________ Relationship to Patient: __________

Signature: ______________________________ Date: ____________

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Private Practices* Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |