Returning Patient Update Form

Personal Information Update

Last Name	First Name	MI	Preferred Name	Date of Birth

☐ My street address has not changed.
☐ My street address has changed. Please list new address: _____

_____

☐ My contact information has not changed.
☐ My contact information has changed. Please list updated contact information: Cell Phone: _____

Secondary Phone: _____ Email Address: _____

Insurance Update

☐ My vision insurance has not changed.
☐ My vision insurance has changed: ☐ VSP ☐ VCP ☐ Other: _____

Subscriber's Name: _____ Subscriber's SSN: _____ Subscriber's DOB: _____

☐ My primary insurance has not changed.
☐ My primary insurance has changed: ☐ Medicare ☐ Blue Cross ☐ United Health Care ☐ Other: _____

Subscriber's Name: _____ Contract Number: _____ Subscriber's DOB: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Health History Update

Primary Care Physician: _____ Date of last physical exam: _____

☐ I have not been diagnosed with any new medical conditions within the past year.
☐ I have been diagnosed with the following conditions within the past year: _____

_____

Please list any medications you take, including over-the-counter medications: _____

_____

Please list any allergies you have to medications, food, materials, dyes, etc.: _____

_____

Please list any major surgeries you have had since your last visit: _____

_____

Are you currently pregnant and/or nursing? ☐ Yes ☐ No	Are you wearing contact lenses today? ☐ Yes ☐ No

HI PAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health In formation, or PHI (Required by the Health Insurance Portabilityand Accountability Act {HIPAA}, 45 CFR Parts 160 and 164)

l. Authorization

I authorize R City Eye Care to use and disclose the protected health information described below to (individual seeing the information) _____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐_____to_____ OR

b. ☐ all past, present, and future periods

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4.The person I authorize to receive this medical information may use it for medical treatment or consultation, billing or claim s payment, or other purposes I may direct

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage, and the in surer has a legal right to contest a claim

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be condition ed on whether I sign this authorization.

7. I understand that in formation used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative_____Date:_____

Printed name of patient or personal representative_____Relationship:_____

** A copy of our full Privacy Policy is available at the front desk**