For Our New Patients

Welcome!

This packet is provided to help you prepare for your upcoming visit with us. Please take a moment to fill out all information included so that we may better serve you.

Inside this packet you will find:

- Welcome letter with helpful tips and information
- Patient Registration Form
- Patient Medical History and Questionnaire
- Notice of Privacy Practices

If you have any questions, feel free to speak with one of our friendly staff members by calling us at (814) 664-8676 for our Corry office and (814) 734-6161for our Edinboro office. Remember to bring your current list of medications and your insurance cards both vision and medical to your visit.

We look forward to serving you!

BLANEY
VISION CENTER

Dr. Scott A. Blaney

420 North Center Street Corry, Pennsylvania 16407
(814) 664-8676

135 Erie Street Edinboro, Pennsylvania 16412
(814) 734-6161

New Patient Information

Today's Date: _____ Your Appointment is scheduled: _____ at _____

Dear Patient,

Welcome to the office of Dr. Scott A. Blaney. We look forward to providing you with the most advanced eye care available in a friendly and caring atmosphere.

In order to lessen your wait time before your examination, **please complete the enclosed forms and bring them with you for your appointment:**

- Patient Registration Form
- Patient Medical History and Questionnaire
- Notice of Privacy Practices

Please remember to bring:

- List of current medications you are taking
- List of any eye medications you are taking
- Insurance cards, both vision and medical

If you are a new patient with Dr. Scott A. Blaney:

- Plan to spend approximately 1-2 hours with us. This time may vary according to tests being performed.
- Your eyes may be dilated. Please bring a companion with you to drive you home, if needed.

Financial Responsibility:

You are responsible for any unmet deductibles and/or co-payments at the end of your visit. If you have any questions, please do not hesitate to call and speak with one of our patient service representatives. We look forward to seeing you and providing you with your medical and optometry needs.

Dr. Scott A. Blaney

Patient Registration Form

Name:_____ Male or Female **Age:**_____ **Birthdate:**_____

Race: (Please circle) Caucasian African-American Asian Native American

Ethnicity: (Please circle) Non-Hispanic Hispanic Not Specified

____Single ____Married ____Widowed ____Separated ____Divorced **Social Security #** _____

Address: _____
Street City State Zip

Home Phone:( ) _____ **Cell Phone:**( ) _____

Work Phone: ( ) _____ **E-Mail Address:** _____

Employer: _____ **Occupation:**_____**Work Phone:**( ) _____

_____Self-Employed _____Unemployed _____Disabled _____Homemaker _____Retired

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Address: _____
Street City State Zip

Contact's Home Phone: ( ) _____Contact's Work / Cell Phone: ( ) _____
(**Please Circle**)

Health History

Primary Care Physician: _____ City: _____ State: _____

Date of last eye examination: _____ Place of last eye exam: _____

List current Medications: _____

_____

Allergies: _____

Current Eye Problems: _____

Diabetic Patients: ___ Type 1 ***or*** ___Type 2 Current BG: _____ A1C: _____

Patient's Height: _____ Patient's Weight: _____ Blood Pressure: ____/____ Pulse: _____
(to be filled out by technician)

Vision **Insurance Information** **Medical**

Insurance Company: _____ Insurance Company: _____

Primary Policy Holder: _____ Primary Policy Holder: _____

Primary Holder's Date of Birth: _____ Primary Holder's Date of Birth:_____

ID# _____Group# _____ ID#_____Group#_____

Assignment and Release

I, the undersigned, have insurance coverage and assign directly to Dr. Scott A. Blaney all medical benefits, if any, otherwise payable to me for services rendered***. I understand I am financially responsible for all charges*** whether or not paid by insurance, including Co-Pays and deductibles. I hereby authorize this facility to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Review of Systems

Date: _____ Name: _____ Account # _____

(To be completed by patient)

SOCIAL HISTORY

Do you drive? ___No ___Yes If yes, do you have visual difficulty when driving? ___No ___Yes

If yes, please describe _____

Do you use tobacco products? ____Yes ____ No ____Quit If yes, for _____ years and _____ per day

Do you drink alcohol? ____Yes ____No If yes, ____Socially ____Frequently / Daily

Health History

REVIEW OF SYSTEMS

Do you currently have or ever had any problems in the following areas?

	Yes	No	If YES, please ***EXPLAIN***
Constitutional: Fever, Weight Loss / Gain			
Eyes: Cataracts, Lazy Eye, Glaucoma, Macular Degeneration, Blurry Vision, Dry Eyes, Other			
Ear, Nose Throat & Mouth: Congestion, Dry Mouth/Throat, Runny nose, Cough			
Respiratory: Asthma, Emphysema, Bronchitis, Sleep Apnea			
Vascular: Diabetes, High Blood Pressure, Vascular Disease, High Cholesterol			
Heart Problems: CAD, Heart Attack, Heart Pain			
Gastrointestinal: Diarrhea, Constipation			
Genitourinary: Kidney, Bladder, Genitals			
Bones, Joints & Muscles: Rheumatoid Arthritis, Joint Pain, Muscle Aches, Arthritis			
Lymphatic/Hematological: Anemia, Bleeding			
Endocrine: Thyroid, other glands			
Neurological: Headaches, Migraines, Seizures			
Psychiatric: Anxiety, Depression			
Skin: Lesions, Rashes, Redness, Discolored Moles			
Allergic / Immunologic			

FAMILY HISTORY

		Relationship			Relationship
Blindness	No Yes ?		Cancer	No Yes ?	
Cataract	No Yes ?		Diabetes	No Yes ?	
Crossed Eyes	No Yes ?		Heart Disease	No Yes ?	
Glaucoma	No Yes ?		High Blood Pressure	No Yes ?	
Macular Degeneration	No Yes ?		Kidney Disease	No Yes ?	
Retinal Detachment	No Yes ?		Lupus	No Yes ?	
Other Eye Disease:	No Yes ?		Rheumatoid Arthritis	No Yes ?	
Other:			Thyroid Disease	No Yes ?	

Patient Privacy & HIPPA

Patient's Name: _____

Please list the family member(s) or other persons, if any, whom we may inform about your eye medical condition and your diagnosis (including treatment, payment and health care options):

_____ _____

Person's Name *Relationship to Patient*

_____ _____

Address Phone: Home / Cell

_____ _____

Person's Name *Relationship to Patient*

_____ _____

Address Phone: Home / Cell

Electronic Record Security Questions:

Patient's *Mother's* Maiden last name: _____

Patient's *State* of birth: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICE ACKNOWLGEMENT

I hereby acknowledge that I received the Notice of Privacy Practice from Dr. Scott A. Blaney, which sets forth the ways in which my personal health information may be used or disclosed by Dr. Scott A. Blaney, and outlines my rights with respect to such information.

_____ _____

Signature of Patient, under 18 years Guardian/Parent Date

Please print the telephone number where you want to receive calls about your appointments or other eye care information, ***if other than your home telephone***

Phone number: ( ) _____ *Is this a cell phone?* ___*Yes* ___*No*

Can confidential messages (i.e. appointment reminders, billing inquiries, and health information) be left on your answering machine or voicemail?

____Yes ____No

How did you find our practice?

____Referral, whom may we thank? _____

____Insurance Accepted ____Telephone Book ____Internet