Plessen Ophthalmology
Comprehensive Eye Care

3006 Orange Grove ● PO Box 910 ● Christiansted, VI 00821
9000 Lockhart Gardens St. 4 ● St. Thomas, VI 00802

PATIENT REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Physician's Name:**	**Referring Provider (who sent you?):**

PATIENT INFORMATION

Patient Last:	**First:**	**Middle:**
Mailing Address:	**Physical Address:**	
Home#:	**Work#:**	**Cell#:**
Birthdate:	**Sex:** ❑ Female ❑ Male	**SSN:**
Marital Status: ❑Married ❑Single ❑Divorced ❑ Widowed ❑Legally Separated ❑Unknown	**Student Status:** ❑Not a student ❑Full-time student ❑Part-time student	
Employed Status: ❑Employed full-time ❑Employed part-time ❑Not employed ❑Self Employed ❑ Retired ❑On active military duty **Place of Employment**: _____	**Residence Type:** ❑Private Home ❑Nursing Home ❑Residential Treatment Patient ❑Skilled Nursing Home	
Ethnicity: ❑Not Hispanic or Latino ❑ Hispanic or Latino	**Language:** ❑English ❑Spanish ❑Other	**Race:** ❑American Indian or Eskimo or Aleut ❑Asian or Native Hawaiian or Pacific Islander ❑Black or African American ❑White ❑Other Race

PRIMARY INSURANCE INFORMATION

Patient relation to the insured? ❑Self ❑Spouse ❑Child ❑Other	**Insured Last:**	**First:**	**Middle:**
Mailing Address:	**City:**	**State:**	**Zip Code:**
Home#:	**Work#:**	**Cell#:**	
Birthdate:	**Sex:** ❑ Female ❑ Male	**SSN:**	
Primary Insurance Name: ❑MEDICARE ❑CIGNA ❑UHC ❑BCBS ❑AARP ❑Other:_____	**Group Number:**	**Member Id#:**	

Plessen Ophthalmology
Comprehensive Eye Care

3006 Orange Grove ● PO Box 910 ● Christiansted, VI 00821
9000 Lockhart Gardens Ste. 4 ● St. Thomas, VI 00802

SECONDARY INSURANCE INFORMATION					
Patient relation to the insured? ❑Self-Spouse ❑Child ❑Other	**Insured Last:**	**First:**	**Middle:**		
Mailing Address:		**City:**	**State:**	**Zip Code:**	
Home#:	**Work#:**		**Cell#:**		
Birthdate:	**Sex:** ❑ Female ❑ Male		**SSN:**		
Secondary Insurance Name: ❑MEDICARE ❑CIGNA ❑UHC ❑BCBS ❑AARP ❑Other: _____	**Group Number:**		**Member Id#:**		

Other Insurance		
Insurance Name:	**Policy Number:**	**Group Number:**

EMERGENCY CONTACT/ GUARDIAN INFORMATION		
Last:	**First:**	**Middle:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Remarks:	**Permission to Speak To?** ❑Yes ❑No	

Patient/Guardian signature: _____ **Date: _____**

Plessen Ophthalmology

3006 Orange Grove • PO Box 910 • Christiansted, VI 00821
9000 Lockhart Garden • Suite 4 • St. Thomas, VI 00802

Name: _____ Date of Birth: _____

Date of last eye exam: _____ With whom: _____

Circle all symptoms or concerns that you would like to have addressed during this visit:

LOSS OF VISION BLURRED VISION HISTORY OF GLAUCOMA HISTORY OF DIABETES HISTORY OF CATARACT ITCHING BURNING REDNESS
FLOATING SPOTS PAIN FOREIGN BODY SANDY FEELING TEARING NEED NEW GLASSES
OTHER: _____

Circle any physical disease you have been diagnosed with: DIABETES HIGH BLOOD PRESSURE HEART DISEASE HIV / AIDS
KIDNEY DISEASE DIALYSIS STROKE ARTHRITIS LIVER DISEASE CANCER MIGRAINE
OTHER: _____

List any eye disease you have been diagnosed with or treated for: _____

List all eye medications that you currently take: _____

List medications you currently take:, not including eye medications: _____

List all surgeries you have had in the past including eye surgery or laser : _____

Do you have any allergies to medications? YES NO (list): _____

Are you currently pregnant or breastfeeding? YES NO

Has any member of your family (parents, siblings, grandparents) had the following (circle all that apply, or circle: NONE)

BLINDNESS GLAUCOMA MACULAR DEGENERATION DIABETES HYPERTENSION HEART DISEASE STROKE ARTHRITIS CANCER

Do you drink alcohol? NO YES how much? _____

Do you smoke? NO YES how much? _____

Do you drive? ☐ YES ☐ NO

Signature (or Parent's Signature): _____ Date: _____

Plessen Ophthalmology

3006 Orange Grove • PO Box 910 • Christiansted, VI 00821
9000 Lockhart Garden • Suite 4 • St.Thomas, VI 00802

Name: _____ Date of Birth: _____

Insurance Benefits Authorization

I request that payment of authorized insurance benefits be made on my behalf to this office for any services furnished by the physician to me. I authorize any holder of medical information about me to release to any health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

Patient Insurance Responsibilities/Self Pay

I understand that I am responsible for self pay payment and payment of deductibles, coinsurance, and copayments as required by my insurance carriers.

Signed: _____ Date: _____

HIPAA Privacy Notice

Our office has always supported and recognized our patients' right to expect that their records and other information about their care will be kept confidential. One of the provisions of the HIPAA privacy regulations is that all healthcare providers distribute a "Notice of Privacy Practices': All patients can receive this notice upon request or read the notice posted in the waiting room. Patients are not required to read this notice, but we are asking that you acknowledge that you have received access to this notice.

Signed: _____ Date: _____

If your visit involves Workman's Compensation please advise the receptionist

3006 Orange Grove Christiansted, VI 00820
Phone: (340) 773-2015 Fax: (340) 719-9590
9000 Lockhart Gardens Ste. 4 St. Thomas, VI 00802
Phone: (340) 774-2015 Fax: (340) 774-9590

Plessen Ophthalmology
Comprehensive Eye Care

Health Insurance Portability and Accountability Act (HIPAA) Privacy Manual

Effective Date: April 14, 2003

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of our patients' Protected Health Information (PHI). This policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of our patients, PHI to the greatest degree possible. Patients should not be afraid to provide information to our practice, physicians and staff for purposes of treatment, payment and health care operations (TPO). To that end, our practice, physicians and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice, our physicians and our staff will not use or disclose PHI for uses outside of the practices TPO, such as marketing, employment, life insurance applications, etc., without authorizations from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patient must be accurate, timely, complete and available when needed. We will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy and to respect their dignity at all times. We will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice, its physicians and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - Not disclose PHI data unless patients (or an authorized representative) have properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although the practice "owns" the medical record, patients have a right to inspect and obtain a copy of their PHI. In addition, patients have a right to request an amendment to their medical records if they believe the information is inaccurate or incomplete. Our practice, its physicians and staff will:
    - Permit patient access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases we will have an on-site health care professional review the patient's appeals.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- Pursuant to an authorization as required by HIPAA rules. We will provide the list to patients upon request, so long as their requests are in writing.
- Adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

Our practice, its physicians, and staff pledge to adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practices personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request. For questions or concerns please feel free to contact the Practice Manager at (340) 773-2015.