DR. MARRA
&ASSOCIATES

Last Name _____ First Name _____

Date of birth _____ Social Security Number_____

If a child, parent or guardian's name _____

Address_____City_____State_____ Zip_____

Email Address_____

Primary Phone Number_____ Is texting ok? Yes_____ No_____

Secondary Number_____

Primary Care Physician_____

Pharmacy_____ Street_____

Occupation (i.e. student, homemaker, ect) _____

Name recreations or hobbies you engage in_____

Primary Vision Insurance_____

Policy Holder_____ DOB_____ SSN_____

Secondary Vision Insurance_____

Policy Holder_____ DOB_____ SSN_____

Primary Medical Insurance_____

Do you smoke? Y__ N__

Do you have headaches often? Y__ N__ If so, how often?_____

Are you currently experiencing any of these **eye symptoms**?

Loss of vision	___	Halos around lights	___	Mucous Discharge	___
Blurred Vision	___	Fluctuating Vision	___	Redness	___
Loss of side vision	___	Dryness	___	Double Vision	___
Excess tearing/watering	___	Distorted Vision	___	Sandy Gritty Feeling	___
Floaters/Flashes	___	Itching	___	Eye Pain or Soreness	___
Burning	___	Glare/Light Sensitivity	___	Foreign Body Sensation	___

Describe any other visual problems_____

Ocular History

Have **you** ever had any of the following:

___ Eye Injury/Trauma (specify)_____
___ Refractive Surgery/LASIK
___ Cataract Surgery
___ Other Eye Surgery (specify)_____
___ Eye Injections
___ Laser Treatments
___ Retinal Hole/Tear/Detachment
___ Head Injury/Trauma (specify)_____
___ Other (specify)_____

Do **you** currently have:

___ Glaucoma
___ Cataracts
___ Macular Degeneration
___ Diabetic Retinopathy
___ Ketatoconus
___ Lazy Eye
___ Other (specify)_____

Medical History

Do **you** have or ever had any of the following:

___ High Blood Pressure
___ High Cholesterol
___ Heart Disease
___ Stroke
___ Diabetes
___ Thyroid Problems
___ Cancer
___ Other (specify)_____

Do any of **your immediate family** members have:

___ High Blood Pressure
___ Diabetes
___ Cancer
___ Macular Degeneration
___ Glaucoma
___ Ketatoconus
___ Other (specify)_____

Allergies to medications: (list may be attached)

_____ _____
_____ _____
_____ _____
_____ _____

Please list your medications: (list may be attached)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Advance Beneficiary Notice of Non coverage: If your insurance does not cover extra materials or services which you have chosen, please sign that you understand you will be paying for them.
Signature: _____

Dr. Marra & Assoicates

Authorization Form Policy / Notice of Privacy Practices

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances include: public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Drs. Marra, and Associates will only use or disclose PHI, except as noted above, consistent with the terms of authorization.

A patient may revoke his/her authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his/her personal representative. It should include the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

I, _____, have read the above Notice of Privacy Practices.
Print Name

_____
Signature

_____
Date