Dr. Steven M. Rapoport, O.D.
25 Rope Ferry Road
Waterford, Connecticut 06385
Telephone (860) 442-5012

Acknowledgement of Receipt: Notice of Privacy Practices

Steven M. Rapoport, Privacy Officer

Name of Patient _____

I hereby acknowledge that I have received a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be posted near the reception area, and that I may request a copy of an amended Notice of Privacy Practices at my appointment.

Signature _____ Date _____

Print Name _____ Telephone _____

If this Acknowledgement is signed by someone other than the patient, please indicate your relationship to the patient: _____

This Section for Office Use Only

Signed Acknowledgement received by _____
Staff Name

Acknowledgement refused _____

Efforts to obtain _____

Reason(s) for refusal _____

***** NEW PATIENT INFORMATION *****

NAME_____ Patient's SS #_____
First MI Last

Home Address_____ City_____ State_____ Zip_____

E-mail Address _____ Date of Birth_____

Telephone (s) Home # _____ Work # _____ Cell# _____

I prefer to receive calls... ____At Home ____ At Work ____On My Cell _____ Any of these

Name of Spouse or Guardian_____

Your Occupation_____ Employer_____
City State

If you are a Student, name of School/College_____
City State

Name of person responsible for this account (if other than self)_____

Relationship to Patient_____ Phone #_____

Address_____City_____State_____ Zip_____

***** INSURANCE INFORMATION *****

Name of Insured_____ Relationship to Patient_____

Date of Birth _____ SS#_____ Name of Employer _____

Address_____ City_____ State____ Zip_____

Insurance Co._____ ID# _____ Group# _____

Address _____ City _____ State ____ Zip _____

How much is your deductible? _____

DO YOU HAVE ADDITIONAL INSURANCE? ____NO YES____ (if yes, please complete below)

Name of Insured_____ Relationship to patient _____

Date of Birth _____ SS#_____ Name of Employer _____

Address _____City _____ State _____ Zip_____

Insurance Co. _____ ID# _____ Group# _____

Address_____ City _____ State _____ Zip _____

How much is your deductible? _____

***** HEALTH HISTORY *****

Name of Physician _____ City _____ State _____ Zip_____

Most Recent Physical Exam (date) _____

Most Recent Complete Eye Exam (date) _____ With Dr. _____

Reason for today's exam? _____

Do you or anyone in your immediate family have a history of any the following?

____ Diabetes ____ Blindness ____ High Blood Pressure

____ Cataracts ____ Thyroid ____ Turned or Lazy Eye

____ Glaucoma ____ Heart Condition ____ Arthritis

Please check any of the following conditions that apply to YOU:

____ Frequent Headaches ____ Drug Allergy ____ Pregnant

____ Sinus Trouble ____ Given birth in last 6 months ____ Allergies

Please list all medication(s) you are taking, including vitamins:

_____

Have you ever had any of the following eye conditions?

____ Eye Surgery ____ Sensitivity to light ____ Eye infection or disease

____ Eye Injury ____ Floaters or Spots ____ Double vision

____ Poor Distance Vision ____ Poor Near Vision ____ Eyes Burn, Itch or Water

Do you currently wear glasses? ___ No ___ Yes

If yes, when do you wear your glasses? _____

Have you ever worn contact lenses? ___ No ___ Yes If yes, what type? _____

Are you interested in wearing contact lenses? ___ Yes ___ No

Do you use a computer or video display terminal daily? ___ No ___ Yes If yes, how many hours? ____

In which sports or hobbies do you participate? _____

Whom may we thank for referring you to our office? _____

_____ _____

Signature of Patient (or Parent/Guardian, if a minor) Date