Boston University Eye Associates, Inc.

HIPAA Form

Patient EHR#

Today's date_____ DOB: _____ Social Security# _____

Last _____ First _____ Middle Initial _____

ADDRESS _____ Apt # _____ CITY_____

STATE_____ ZIP CODE_____ Email: _____

Primary Language: _____

Race (Please circle): American Indian / Alaska Native Asian Black / African American
Native Hawaiian / Pacific Islander White Other: _____

Ethnicity (Please Circle): Hispanic or Latino / NOT Hispanic or Latino

Home Phone: _____Work Phone: _____Cell Phone: _____
Ok to leave messages at (check all that apply) **Home____ Work _____ Cell_____**

Primary Care Physician: _____ Town: _____
Did they refer you here? Yes_____ No _____ **Phone _____**

Pharmacy Name_____ Address _____Town _____

If "Insurance Subscriber" information is different than the patient, please provide the following:

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

Responsible Party (if under 18):

Name: _____ DOB:_____

Address _____City _____State_____Zip Code _____

IN CASE OF EMERGENCY CONTACT: _____

Relationship to Patient: _____

Home / Work #:_____ Cell #: _____

My Signature Indicates:

1. I give the following persons permission to have information about my medical record.
   **** If applicable (under 18) – In my absence I give permission to BRING my child to their visit.**

   _____ _____ _____

2. I authorize the staff of Boston University Eye Associates to administer eye drops which are required for the eye exam.

3. **Acknowledgement of Receipt of Notice:**
   I've been offered the opportunity to read Boston University Eye's Associates "Notice of Privacy Practices"

Signature of Patient, Parent or Guardian: _____ Date: _____