PATIENT INFORMATION SHEET

Name: Last: ________________________ First: ______________________ Today's Date: ______________
Address: ____
City: _______________ St:____ Zip Code: _________
Birth Date: _____________ Age: _______ M☐ F☐ SSN: _______________
Home Phone: _________________ Cell: _______________ E-mail: __________________________________
Occupation/Hobbies: _______________________ Name of Primary Care Doctor: _____________________
Do you authorize text alerts from our office? Y ____ N____ (carrier message and data rates may apply)
Referred by: ______________________________

Insurance Information:

Vision Insurance: ___________________________
Member ID: _______________________________
Policy Holder's Name:________________________
Policy Holder's Birth Date: ___________________
Policy Holder's SS#: ________________________
Relationship to Patient: ______________________

Medical Insurance:______________________
Member ID: ____________________________
Group #: _______________________________

What is your reason for today's visit?

Glasses ____ Blur at Near ____ Discharge/Tears ____ Flashes/Floaters ____
Contact Lenses ____ Red Eye ____ Double Vision ____ Severe Dry Eyes ____
Blur at Distance ____ Itching ____ Lazy Eye/Eye Turn ____ Eye Pain/Discomfort ____

Last eye exam: _____________ How old are your current glasses? __________

If you wear contacts please answer the following:
Type: ___ Soft Daily Wear ___ Soft Extended Wear ___ Toric ___ Rigid Gas Permeable
Current brand of contact lenses: ___________________

Have you had previous eye surgery? ___ No / ___ Yes, Explain: ____________________________
Have you had an eye injury? ___ No / ___ Yes, Explain: _______________________________

Are you now pregnant? ___ No / ___ Yes Do you smoke? ___ No / ___ Yes, Packs/day:________
Do you have any allergies or sensitivities? ___ No / ___ Yes, Explain: ___________________________
Do you take any medications? ___ No / ___ Yes, Please list: ____
____
____

Medical/Ocular History: Do you have or have you ever had:

	Self / Family		Self		Self
High Blood Pressure	___ / ___	Breathing Problems	____	STD	____
Diabetes (Type 1 / Type 2)	___ / ___	Kidney/Urinary	____	HIV/AIDS	____
Asthma	___ / ___	Sinus/Allergy	____	Cancer	____
High Cholesterol	___ / ___	Thyroid/Glands	____	Skin Condition	____
Blindness	___ / ___	Depression/Anxiety	____	Heart Disease	____
Retinal Disease	___ / ___	Arthritis/Joint Pain	____	Other __________________	
Glaucoma	___ / ___	Hearing loss	____	________________________	
Macular Degeneration	___ / ___	Stroke	____	________________________	
Cataracts	___ / ___	Headache	____	________________________	

DILATION RELEASE AUTHORIZATION

The purpose of dilating your pupil is to perform a more thorough examination of the health of your retina by viewing through the iris or colored area. This allows the doctor access to the peripheral retina, which would normally be blocked. Individuals with diabetes, glaucoma, high prescription, systemic diseases, and those over 55 years old are strongly encouraged to have this procedure. Certain side effects which may occur and are common are blurry vision, nausea, dry mouth, light sensitivity, and burning of eyes upon the instillation of drops. ***Blurred Vision typically lasts about 3-4 hours***.

PLEASE SELECT ONLY *ONE* OPTION BELOW:

___I have read the previous statement and **ACCEPT** a dilated exam and digital retinal photos.
___I have read the previous statement and **ACCEPT** a dilated exam only.
___I have read the previous statement and **ACCEPT** to have digital retina photos only.
___I have read the previous statement and **DECLINE** both dilated exam and digital retinal photos.

Patient Signature (parent if minor*): ________________________________ Date: __________

Lifetime Authorization Insurance Assignments and Authorization to Release Information

Release of Information: I, below named patient, do hereby authorize any physician examining and/or treating me to release to any third party payer (such as insurance company or government agency, such as Eyemed or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for use in connection with determining a claim for payment for such treatment and diagnosis.

Physician Insurance agreement: I hereby authorize payment directly to any physician examining or treating me for medical benefits otherwise payable to me for their services but not to exceed the reasonable and customary charge for these services.

Medicare: I certify that I information given to me is correct. I authorize any holder of medical information about me to release to social security administration or its intermediaries any information needed for a Medicare claim. I hereby certify all insurance payments shall be assigned to the physician treating me.

I permit a copy of these authorizations and assignments be used in place if the original which is on file at the physicians office. The assignment will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT

1. Your insurance is a contract between you and your insurance company; we are not a party to that contract.
2. Not all services are covered benefits under all contracts. All non covered services, such as refractions for Medicare, are the financial responsibility of the patient.
3. **I understand that it is my responsibility to pay any deductible amount, co- insurance or any other balance not paid for by my insurance company within a reasonable amount of time, not to exceed 60 days.**
4. If this account id assigned to an attorney for collections and /or suit to collection agency, the prevailing party shall be entitled to attorney's fees and costs of all collections.

I have read and understand the above financial policy. ***SIGNATURE*:*** ________________________________

HIPAA PATIENT CONSENT FORM

I understand that under the HIPA act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct plan and direct my treatment, follow up among the multiple healthcare providers that may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices and may request a copy. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictyions but if you do agree then you are bound to abide by such restrictions.

SIGNATURE*: ____