

PATIENT INFORMATION SHEET

Name: Last: _____ First: _____ Today's Date: _____
Address: _____ Apt/Unit #: _____
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?

Routine Exam Blur at Near Discharge/Tears Flashes/Floaters
Glasses/Contacts ___/___ 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:

	<u>Self</u> / <u>Family</u>		<u>Self</u>		<u>Self</u>
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 restrictions but if you do agree then you are bound to abide by such restrictions.

SIGNATURE*: _____