

EYES ON HENRY

Patient Information	Insurance Information
Today's Date _____ Last _____ First _____ MI _____ Preferred Name _____ Street _____ City _____ State _____ Zip Code _____ Home Phone _____ Work Phone _____ Cell Phone _____ Email Address _____ Patient's SSN _____ Employer (or School) _____ Occupation (or Grade) _____ Spouse (or Responsible Party's Name) _____ Spouse (or Responsible Party's Work) _____ Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Date of Birth _____ Age _____ Sex M F Emergency Contact Name _____ Emergency Contact Number _____ What is the major purpose of this visit? _____ _____ VERY IMPORTANT! NEW PATIENTS ONLY: Who may we thank for referring you to our office? Name of friend or relative _____ If not referred, how did you choose our office? <input type="checkbox"/> Another Dr. <input type="checkbox"/> Insurance List <input type="checkbox"/> Saw Sign/Building <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____	Vision Insurance _____ Policy/ID Number _____ Group Number _____ Subscriber's Name _____ Subscriber's SSN _____ Subscriber's Birth Date _____ Subscriber's Employer _____ Primary Medical Insurance _____ Policy/ID Number _____ Group Number _____ Subscriber's Name _____ Subscriber's SSN _____ Subscriber's Birth Date _____ Secondary Medical Insurance _____ Policy/ID Number _____ Group Number _____ Subscriber's Name _____ Subscriber's SSN _____ Subscriber's Birth Date _____
Lifestyle Questions	
<p>Do you...(check box if your answer is yes)</p> <input type="checkbox"/> .spend time on the computer? How many hrs/day? ____ <input type="checkbox"/> .think you might benefit from thinner, lighter lenses? <input type="checkbox"/> .find yourself bothered by glare or reflection, particularly when night driving? <input type="checkbox"/> .spend time outdoors? How many hrs/week? ____ <input type="checkbox"/> .have sun wear (prescription and/or non-prescription)? <input type="checkbox"/> .prefer not to wear your glasses at times? <input type="checkbox"/> .want information on Laser Vision Correction surgery? <input type="checkbox"/> .have a spare pair of glasses in your current Rx? <input type="checkbox"/> .have family members or friends in need of eyecare?	
<p>Have you ever experienced, been diagnosed or treated for any of the following?</p> <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Flashes of Lights <input type="checkbox"/> Sunlight Sensitivity <input type="checkbox"/> Eye Infections <input type="checkbox"/> Trouble seeing at night <input type="checkbox"/> Eye Injury <input type="checkbox"/> Itchiness <input type="checkbox"/> Cataracts <input type="checkbox"/> Grittiness <input type="checkbox"/> Crossed eye/Eye Turn <input type="checkbox"/> Burning <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Tearing <input type="checkbox"/> Glaucoma <input type="checkbox"/> Double Vision <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Floaters/Spots <input type="checkbox"/> Iritis/Uveitis <input type="checkbox"/> Other eye disorders _____	
<p><i>The mission of this practice is to meet our patients' comprehensive visual and ocular health care needs and exceed their expectations in a friendly, compassionate, and educational atmosphere, nurturing lasting relationships with patients of all ages.</i></p>	

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History	
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____	
Preferred Pharmacy _____ Street _____ City: _____	
Have you had any major surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list _____ _____	
Tobacco Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Alcohol Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____ Drug Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____	
Have you ever been diagnosed or treated for the following health problems?	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood/Lymph	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestive	<input type="checkbox"/> Eczema/Rashes
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Integumentary (Skin)	<input type="checkbox"/> Kidney
<input type="checkbox"/> Muscle/Bone	<input type="checkbox"/> Neurological
<input type="checkbox"/> Psychological	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Thyroid	

Patient Eye History	
Date of Last Eye Exam _____ By Whom? _____	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you don't wear contacts, would you be interested in being fit for them <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
	Relationship
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, we require a valid copy of your insurance card to ensure that your claims are filed properly. We will file your insurance for you as a courtesy, however if your insurance does not cover a particular service, you will be responsible for the balance, any copays, deductibles, and/or contact lens fitting fees. Payment of these is due at the time of the service.

By signing, you authorize your insurance company to make payment to this practice for services and material provided. You authorize the practice to deposit checks received on your account if made out to you, the patient. You authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on your behalf.

Signature _____ Date: _____

Authorization for Release of Information

This form authorizes Eyes on Henry to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mail/answering machine messages.

I consent to the release of (please check all that apply):

Financial/Billing Information

Medical Care (treatment plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

Patient's voice mail/answering machine

Voice mail/answering machine of (e.g. spouse, parent, sibling)

Name/Relationship to patient

Phone#

Name/Relationship to patient

Phone#

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Eyes On Henry. I understand a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing This authorization shall be in effect until revoked by the patient.

(Signature of Patient (parent or legal guardian if patient is a minor))

Acknowledgement of Notice of Privacy Practices

Eyes on Henry will provide me a copy of their Notice of Privacy Practices up request.

(Please initial)

Digital Retinal Imaging

In keeping with our mission to provide the latest technology in caring for your eyesight, we offer an elective procedure, digital retinal imaging. The retinal camera takes an image of the optic nerve and retina. The images are added to your medical records assisting your doctor in the early detection of glaucoma, diabetic retinopathy, macular degeneration, retinal tears, and other visual threatening conditions.

The cost for this procedure is \$35. This is an additional out of pocket expense, and is not covered by vision or medical insurance. If these photos detect a medical condition, we may be able to file the fee to your medical insurance, but in most cases this cannot be determined prior to taking the photo.

Because of known risk factors, we strongly recommend these photos for the following:

- History or Family history of glaucoma
- History or Family History of Diabetes
- History or Family History of High Blood Pressure
- History or Family History of High Cholesterol
- History or Family History of Macular Degeneration
- Over the Age of 40
- Headaches
- Spots or Flashes of Light

_____ I elect to have this \$35 procedure.

_____ I decline this additional procedure.