

WELCOME TO OUR OFFICE

Today's Date: _____

(Please Note: If patient is under the age of 18, **Parent or Guardian Information** must be completed.)

Patient's Last Name _____ First Name _____

Date of Birth ____ / ____ / _____ Age ____ Male/Female ____ Soc. Sec. # _____

Home Phone # _____ Work # _____ Cell # _____

Street Address _____

City _____ State _____ Zip Code _____

Are other family members treated here? Y ____ N ____ If so, who? _____

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

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Employer Address _____

PARENT OR GUARDIAN INFORMATION

Name _____

Date of Birth _____

Employer _____

Occupation _____

Home Phone _____

Cell Phone _____

Work Phone _____

SPOUSE INFORMATION

Name _____

Date of Birth _____

Employer _____

Occupation _____

Home Phone _____

Cell Phone _____

Work Phone _____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance Co _____

Name of Insured _____

Social Security # _____

Member ID _____

Insured's Date of Birth _____

Relationship to Insured _____

Secondary Insurance

Name of Insurance Co _____

Name of Insured _____

Social Security # _____

Member ID _____

Insured's Date of Birth _____

Relationship to Insured _____

Third Insurance

Name of Insurance Co _____

Name of Insured _____

Social Security # _____

Member ID _____

Insured's Date of Birth _____

Relationship to Insured _____

Fourth Insurance

Name of Insurance Co _____

Name of Insured _____

Social Security # _____

Member ID _____

Insured's Date of Birth _____

Relationship to Insured _____

INSURANCE DISCLAIMER

As a courtesy, our office will bill your insurance company on your behalf. Please understand that we do not have control over the coverage provided by your insurance plan, the benefits you have selected, or the time it takes your insurance company to process and pay a claim. Although we accept assignment from many insurance carriers, **you are ultimately responsible for any balance due on your account**, including amounts not covered or paid by your insurance. We allow up to 90 days from the date of billing for your insurance company to process and pay the claim. If payment has not been received within this time frame, we ask that you make arrangements with our office to pay any outstanding balance.

Please remember that submitting a claim to your insurance company is a courtesy provided by our office and does not relieve you of financial responsibility for your account.

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

In the course of providing healthcare services to you, our office creates, receives, and maintains health information that may identify you. It may be necessary for us to use or disclose this information for purposes of providing treatment, obtaining payment for our services, and conducting the healthcare operations of our office.

The **Notice of Privacy Practices** provided to you explains these uses and disclosures in greater detail. You may review the Notice of Privacy Practices at any time before signing this form.

As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes may include the care and services provided by our office, as well as sharing information when necessary or appropriate to coordinate or facilitate follow-up care with another healthcare professional.

The use and disclosure of your health information for payment purposes may include, but is not limited to:

1. Submitting your health information to billing agents or vendors for the processing of claims or collection of payment.
2. Submitting claims to third-party payers or insurance companies for claims review, benefit determination, and payment.
3. Providing your health information to auditors or other representatives working on behalf of third-party payers or insurance companies.
4. Other activities related to payment as described in our **Notice of Privacy Practices**.

Our **Notice of Privacy Practices** will be updated whenever there are changes to our privacy practices. You may request an updated copy from our office at any time.

By signing this consent form, you acknowledge and agree that our office may use and disclose your health information as necessary to provide treatment, obtain payment for our services, and conduct healthcare operations. By signing, you also acknowledge that you have received a copy of our **Notice of Privacy Practices**.

You have the right to request restrictions on the use or disclosure of your health information for purposes of treatment, payment, or healthcare operations. As described in our **Notice of Privacy Practices**, our office is not required to agree to a requested restriction. If we agree to a restriction, however, we are required to abide by it. The **Notice of Privacy Practices** explains how to submit a request for a restriction.

ACKNOWLEDGMENT AND CONSENT

I have read and understand this document. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received a copy of the Notice of Privacy Practices from **In Focus Eye Care Center**.

Patient Name: _____ **Date** _____

Patient/Authorized Representative Signature: _____

Date: _____

If signed by someone other than the patient, relationship to patient: _____

Source of Authority: _____

MEDICAL HISTORY

Patient's Name _____ Date _____

List any allergies to medications: _____

List all medications you take; including oral contraceptives, aspirin, over the counter medications and home remedies:

List all medical conditions you are being treated for: _____

List all major injuries, surgeries, and hospitalizations you have had: _____

Are you pregnant and/or nursing? __Yes __No Do you wear glasses? __Yes __No

Do you wear contact lenses? __Yes : __Soft Disposable __Gas Permeable __No

General Health Review Have you ever had problems with any of the conditions listed below? **Please check all that apply.**

ENT

☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis
☐ Other _____

Respiratory

☐ Cigarette Smoker
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic Obstruction
☐ Sleep Apnea
☐ Other _____

Integumentary

☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes Simplex/Cold Sores
☐ Herpes Zoster/Shingles
☐ Other _____

Endocrine

☐ Type 2 Diabetes
☐ Type 1 Diabetes
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction
☐ Other _____

Neuro

☐ Multiple Sclerosis
☐ Epilepsy
☐ Cerebral Palsy
☐ Tumor
☐ Stroke/CVA
☐ Migraines
☐ Autism
☐ Seizures
☐ Other _____

Gastrointestinal

☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease
☐ Diarrhea
☐ Constipation
☐ Other _____

Genitourinary

☐ Kidney
☐ Prostate Cancer
☐ STD Herpetic/Chlamydia
☐ Benign Prostate Hypertrophy
☐ Pregnancy/Nursing
☐ Herpes
☐ Other _____

Constitutional

☐ Developmental Disabilities
☐ Cancer
☐ Fatigue Syndrome
☐ Other _____

Allergic/Immune

☐ Drug Allergies
☐ Environmental
☐ Rheumatoid Arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Other _____

Cardiovascular

☐ Hypertension
☐ Stroke
☐ Heart Disease
☐ Vascular Disease
☐ Congestive Heart Failure
☐ Other _____

Musculoskeletal

☐ Osteoarthritis
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Ankylosing Spondylitis
☐ Osteoporosis
☐ Gout
☐ Other _____

Homologic/Lymphatic

☐ Anemia
☐ Large Volume Blood Loss
☐ Ulcer
☐ Hypercholesteremia
☐ Other _____

Psychological

☐ Depression
☐ Attention Deficit Disorder
☐ Anxiety Disorder
☐ Bipolar
☐ PTSD
☐ Other _____

☐ **None of These**

Eyes (Mark all that applies to you)

- ☐ Flashes/Floaters in Vision
- ☐ Amblyopia (Lazy Eye)
- ☐ Blurred Vision
- ☐ Chronic Infection of Eye or Eyelid
- ☐ Distorted Vision/Halos
- ☐ Double Vision
- ☐ Dryness/Gritty Feeling
- ☐ Excess Tearing/Watering
- ☐ Eye Pain or Soreness
- ☐ Foreign Body Sensation
- ☐ Glare/Light Sensitivity
- ☐ Itching Burning
- ☐ Loss of Vision
- ☐ Redness
- ☐ Retina Detachment
- ☐ Strabismus
- ☐ None of These

Family History

Have any of your immediate family members (parents, siblings, children, etc...) ever had any of the following diseases or conditions?

Please indicate who:

- ☐ Amblyopia (Lazy Eye)
- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes
- ☐ Advanced Retinal Disease (Disorder)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Macular Detachment/Disease
- ☐ Retinal Detachment/Disease
- ☐ Thyroid Disease
- ☐ Other
- ☐ None of These

Social History

This information is kept confidential. If you prefer, you may discuss these with the doctor.

- Do you use tobacco products?

☐ Yes

☐ No
- Do you drink alcohol?

☐ Yes

☐ No
- Do you use illegal drugs?

☐ Yes

☐ No
- Do you currently drive?

☐ Yes

☐ No

The above information is accurate to the best of my knowledge.

Signature

Date

IN FOCUS

EYE CARE CENTER

Neil K. Dickerson, O.D.

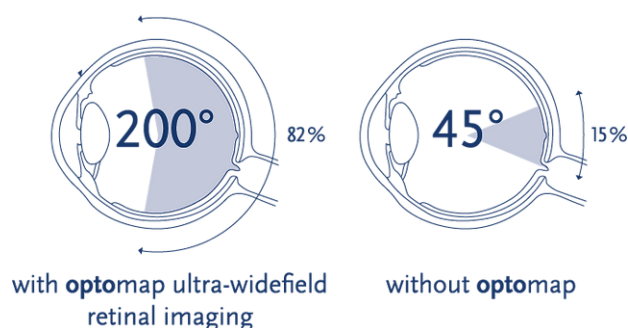


optomap®

ultra-wide digital retinal imaging

We are proud to offer the latest in retinal imaging, the Optomap. Quick and painless, it is the doctor's preferred method of looking at the health of your eyes. Optomap imaging enhances our ability to detect and monitor retinal defects associated with common systemic diseases and conditions such as *hypertension, diabetes, high cholesterol, and thyroid problems*. Through this digital imaging of the retina, we can observe early changes in the eye related to glaucoma, cataracts, and macular degeneration. This technology is part of our high standard of care.

****Most insurance companies do not cover Optomap imaging. Should your vision insurance not cover this procedure, there will be a nominal fee of \$30.****



Please select one of the following:

☐ Yes, I would like Optomap Retinal Images and agree to the \$30 fee.

☐ No, I would not like Optomap Retinal Images

☐ I would like to discuss this with the doctor.

Print Name _____

Date _____

Signature _____