Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Today's Date:**_____

Primary Care Doctor: _____

First and Last Name Address/ Location Phone #

Pharmacy: _____

Name Address/ Location Phone #

Medical History:

For each category, circle any/all conditions that apply to you as a current or past condition or CHECK NONE.		**None**
OPHTHALMIC	Blepharitis Dry eye Cataracts Detached retina Eye Injury/trauma Glaucoma Hyperopia Keratoconus Macular degeneration Myopia Thyroid eye disease Uveitis Blindness Double vision Prism in glasses Loss of peripheral vision Eye drifts inward or outward Floaters Diabetic eye disease Droopy lids Tear duct issues Do you wear contacts/glasses? (circle) Other _____ **Primary Eye Doctor**_____	
ALLERGY	Seasonal allergies itchy redness hives Other_____	
IMMUNOLOGIC	Herpes simplex HIV/AIDS Immunocompromised Lupus Multiple sclerosis Myasthenia gravis Sjogren's syndrome Other Autoimmune disease (please specify) _____ Other _____	
CARDIOVASCULAR	Heart attack High blood pressure High cholesterol Irregular heartbeat Heart murmur Pacemaker Internal defibrillation Other_____	
ENDOCRINE	Type 1 Diabetes Type 2 Diabetes Graves' disease Hyperthyroid Hypothyroid *Take GLP-1 Medication* Other_____ **Endocrinologist Name:** _____	
GASTROINTESTINAL	Crohn's disease Diverticulitis GERD IBS Ulcers Other_____	
GENITOURINARY	Kidney disease Kidney stones On dialysis Prostate disease Painful/frequent urination Blood in urine Other_____	
HEMATOLOGIC/ ONCOLOGIC	Anemia Blood clots Cancer (specify) _____ Bleeding problems *Take blood thinning medication/supplement* Other_____	
EARS, NOSE, THROAT	Hearing loss Sleep apnea Vertigo Sinus congestion Dry mouth Tinnitus Use C-PAP Other_____	
DERMATOLOGIC	Eczema Psoriasis Rosacea Skin Cancer **Dermatologist Name**: _____ Benign growths Rash Other_____	
FEMALE PATIENTS	Are you pregnant? Yes No Are you currently breastfeeding? Yes No Menopause? Yes No	
MUSCULOSKELETAL	Arthritis Fibromyalgia Rheumatoid arthritis Joint pain or swelling Other_____ **Rheumatologist Name:** _____	
NEUROLOGIC	Alzheimer's Dementia Migraines Paralysis Parkinson's Seizures Stroke Memory loss Numbness Tremor Other_____	
PSYCHIATRIC	ADD/ADHD Anxiety Bipolar disorder Depression Schizophrenia Other_____	
RESPIRATORY:	Asthma COPD Severe pulmonary hypertension Wheezing Shortness of breath Cough Continuous oxygen Other _____	
CONSTITUTIONAL	Fatigue Headaches Fainting Dizziness Significant weight loss/gain Body mass index over 50	

List all EYE surgeries (including laser procedures):

_____

_____

_____

List all OTHER MAJOR surgeries you have had:

_____

_____

_____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Today's Date:**_____

Family History

☐ Family history unknown

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type(s) of cancer: _____			

Social History:

Occupation:_____ **Hobbies:** _____

Do you currently drive? (circle) Yes No

Do you smoke? (circle one) Never smoker Former smoker Light smoker Heavy Smoker

Do you drink alcohol? (circle one) None Occasionally/socially 1-2 drinks/day 3-4 drinks/day More than 4 drinks a day

Allergies:

☐ **No known allergies**

Please list all drug allergies below as well as any allergies to latex, adhesive products, bandages, etc.

Allergen	Severity (mild, moderate, severe)	Type of reaction (rash, hives, nausea, anaphylaxis, etc)

Medications & Vitamins:

☐ **Not currently taking any medications of vitamins**

Please list all prescription AND over-the-counter (OTC) medications and vitamins/supplements that you take. **If you have a printed or pre-written list of medications/supplements, please provide it to the front desk instead of listing them here.**

Medication/Vitamin	Dose/Frequency	Reason for taking

Patient Registration

Patient Name _____ **Date of Birth** _____
Last First Middle

Gender __ _____ **Social Security #** (Last 4 digits only) _____ **Email Address** _____

Home Address _____
Street Apt/Unit # City State ZIP

Preferred Phone Number _____ Home Cell Work Other (please specify) _____

Do you agree to receive text message appointment reminders from our office? YES NO If you mark yes, a text to confirm will be sent.

Alternate Phone Number #1 _____ Home Cell Work Other (please specify) _____

Alternate Phone Number #2 _____ Home Cell Work Other (please specify) _____

Employment Status (circle one) Full-time Part-time Retired Unemployed Student

Employer (Parent's employer if minor) _____ **Work Address** _____

Marital Status (circle one) Single Married Divorced Widowed Life partner **Spouse name** _____

Parent/guardian name if minor _____

Emergency Contact Name: _____ **Relation**:_____ **Phone:** _____

Preferred Language _____ **Race/Ethnicity** _____

If applicable, please tell us who referred you (circle one) Doctor/care provider _____ Family Friend Internet
Name of referring doctor

Please read below to better understand your benefits for your annual eye exam appointment.

A basic annual eye exam consists of two portions, the comprehensive eye exam to check the health of your eye and the refraction to determine if there is a need for corrective eyeglasses or contact lenses.

For insurance purposes. a **medical comprehensive eye exam** has a symptom such as headache, bloodshot, pain; and produces a diagnosis, like conjunctivitis, dry eye, glaucoma, age related macular degeneration, or cataracts, to mention a few. A **routine eye exam** is defined by insurance companies as an office visit for the purpose of checking vision, screening for eye disease, and/or updating eyeglass or contact lens prescriptions. These exams have no symptoms and no medical diagnosis, but have a vision diagnosis such as myopia, presbyopia, hyperopia or astigmatism. Medicare and most commercial insurance plans do not cover claims for a vision only diagnosis comprehensive exam.

The refraction (reading the eye chart to achieve best corrected vision) is an essential part of an eye examination whether routine or medical and is required to write a prescription for glasses or contact lenses. At times, it is medically necessary to perform a refraction to help determine the cause of visual changes. This is particularly helpful when patients have multiple issues affecting their eyes such as cataract, glaucoma and macular degeneration. Refractions are a non-covered benefit under Medicare and most commercial insurance plans. Refractions are sometimes covered once a year under medicare advantage plans, HMO plans, and some commercial policies. The fee is $65.00. .

I have read and understand the above:

_____ _____
Patient signature (or authorized representative) Date

Insurance Information and Financial Consent

- **PLEASE MAKE SURE THE FRONT DESK HAS A COPY OF YOUR CURRENT MEDICAL INSURANCE CARD(S).**
- **ALL EXAMINATIONS ARE SUBMITTED TO YOUR MEDICAL INSURANCE.**
- **FOR HMO PLANS, INSURANCE AUTHORIZATION/REFERRAL MUST BE AQUIRED AND ON FILE BEFORE YOUR APPOINTMENT.**
- **WE DO NOT PARTICIPATE IN ANY VISION PLANS.**

Primary Insurance Carrier _____ **Secondary Insurance Carrier (if applicable)** _____

Is your insurance through an employer? YES NO

Who is the insurance policy holder? SELF OTHER

NAME, DATE OF BIRTH, RELATION OF INSURED_____

Are you personally responsible for the payment of any fees from your visits at Ophthalmology Partners, LTD? Yes No

If no, who is? Please list name & relation: _____

Is your appointment related to an injury that occurred at work or as part of a workman's compensation claim? Yes No

If yes, who is responsible? Please list employer, contact name & phone number _____

Financial Statement

It is my responsibility to check with my insurance carrier prior to my office visit to check my benefits, copay and deductible' and to confirm that my doctor is classified as a in network provider with my plan. If my policy requires a referral/authorization, it is my responsibility to present it at the time of the visit.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I understand that I am financially responsible to OPL, LTD for any covered or non-covered services as defined by my insurer. Copays, refraction fees and any cosmetic fees are due at the time of the visit. I understand that if I am billed for over 3 billing cycles a $25 fee will be added to my balance. If my account is referred to a collection agency, a collection fee of 30% of the overdue balance will be added to the amount due to cover costs for collection agency fees. I understand that I am financially responsible for the added fees to my balance due to payment delinquency.

_____ _____

Patient signature (or authorized representative) Date

_____

Print name

Patient Name _____ **Date of Birth** _____

Notice of Privacy Practices

The Notice of Privacy Practice (NPP) tells you how we may use and share your health records. It also describes your rights with respect to your health records.

- We will use and share your health records to provide your medical care.
- We will use and share your health records to bill for our services and to collect payment from you or your insurance company.
- We will use and share your health records to run our business. (i.e. mandatory government/public health reporting)
- We will use and share your health records as required/allowed by law (i.e. workers compensation)

I acknowledge understanding of the Notice of Privacy Practices (NPP).

_____ _____

Patient Signature (or authorized representative) Date

Communication Consent

By signing below, you are giving permission to physicians and staff of Ophthalmology Partners, Ltd. to communicate with you and/or your other healthcare providers through the following methods. Please note: this may include messages containing medical and/or financial information. We take steps to ensure the confidentiality of your health information but security breaches of electronic communications are always a remote possibility.

☐ On my cell phone ☐ Voicemail

☐ At home ☐ Text

☐ At work ☐ Email

_____ _____

Patient Signature (or authorized representative) Date

Release of Medical Information

I give authorization to the doctors and staff of Ophthalmology Partners, Ltd. to discuss my medical and/or financial information with the following people.

(1) _____ _____ _____
Name Relation Phone

(2) _____ _____ _____
Name Relation Phone

(3) _____ _____ _____
Name Relation Phone

_____ _____

Patient Signature (or authorized representative) Date