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You have an upcoming appointment with one of our physicians. As a new patient we would like to provide you with some information you will need to know before your visit.

**If your appointment is for a cataract evaluation,**

**please do not wear any contact lenses 2 weeks prior to your examination.**

The average length of time for an appointment is one to one and half hours. Times can vary depending on dilation and testing. In order to keep your visit within this range, please complete the enclosed patient paperwork and bring it with you at the time of your appointment.

Due to the ever-increasing cost of billing procedures, and in an effort to keep from raising our fees, all copays and payments are due the day services are rendered. All payments for materials, including glasses and contacts, must be paid in full on the date ordered.

If you are a participant in a medical insurance plan whereby, we are listed as providers, we will be glad to file your insurance for you. If you do not have your insurance card with you at the time of your visit, we will have to reschedule your appointment for another day.

**SO, PLEASE BRING YOUR INSURANCE CARDS (MEDICAL AND VISION)**

**AS WELL AS A PHOTO ID WITH YOU.**

As we are Medicare, participating physicians, we will file all Medicare. Patients are responsible for 20% of Medicare’s allowable charges, any deductions not satisfied, and all non-covered services.

REFRACTION FEE

CPT CODE 92015

$40.00

This is a part of the eye exam that is for the purpose of prescribing, fitting, or changing glasses.

Since all insurance carriers, including Medicare, consider this routine, it is not a covered expense.

Therefore, it is the patient’s responsibility.

Please check your insurance policy before your visit to make sure what coverage is.

If you have any further questions, please feel free to contact us at 478-744-1710

Logo, company name

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Retinal Imaging is a valuable part of a comprehensive eye exam. This important feature allows our doctors to better evaluate the back of the eye as well as discuss and show the images with you during the exam. Additionally, it provides a baseline image and allows for future comparison. **Some insurances will cover but if not, there is a $39.00 charge for this service.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed) Date of Birth

I would like retinal imaging performed on today’s visit:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

I **decline** retinal imaging on today’s visit:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

|  |  |
| --- | --- |
| **PATIENT** | NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HOME PHONE: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_  SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SEX: M  F  SINGLE  MARRIED  WIDOWED  DIVORCED  EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_ ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *NAME OF EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_*  **If Patient is a Minor**  PARENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  PARENT SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PATIENT INFORMATION**

|  |  |
| --- | --- |
| **GUARANTOR** | **PRIMARY INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: SELF  SPOUSE  CHILD  SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  **SECONDARY INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: SELF  SPOUSE  CHILD  SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration of its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this Authorization to be used in place of the original, and request payment of Medical Insurance Benefits either to myself or to the part who accepts assignment. Regulations pertaining to Medicare Assignment or Benefits apply. I also request that payment under the Medical Insurance Program be made either to me or to Vision Eye Group on any bills for services furnished to me by that group. I understand that I am financially responsible to the physician for charges not covered by this assignment. A copy of this authorization shall be valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

**DILATION CONSENT**

Dilating drops are used to dilate or enlarge the pupils of the eye allowing our physicians to get a better view of the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. Because driving may be difficult after an examination, it’s best if you make arrangements not to drive yourself.

If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

**I hereby authorize Vision Eye Group to administer dilating eye drops.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

**WRITTEN ACKNOWLEDGMENT FORM**

I hereby acknowledge receipt of Vision Eye Group’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

**-OR-**

For Minor (Parent or Legal Guardian)

I am a parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient Name). I hereby acknowledge receipt of Vision Eye Group’s

Notice of Privacy Practices with respect to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or person authorized to sign patient)           Date

Relationship to Patient: \_\_\_Parent \_\_\_Legal Guardian

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**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE READ CAREFULLY**

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (“PHI”) is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

* + Treatment means providing, coordination, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
  + Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
  + Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
  + This practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fund-raising communications, that may be of interest to you. You do have the right to “opt out” with respect to receiving fund-raising communications from us.

The following use and disclosures of PHI will only be made pursuant to use receiving a written authorization from you:

* Most uses and disclosure of psychotherapy notes
* Uses and disclosure of your PHI for marketing purposes, including subsided treatment and healthcare operations
* Disclosures that constitute a sale of PHI under HIPPA
* Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You may have the following rights with respect to your PHI.

* The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosure of family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
* The right to reasonable requests to receive confidential communication of Protected Health Information by alternative means or at alternative locations.
* The right to inspect and copy your PHI
* The right to amend your PHI
* The right to receive an accounting of disclosures of your PHI
* The right to obtain a paper copy of this notice from us upon request.
* The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to your PHI.

This notice is effective as of April 19, 2019 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You may recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

**MEDICAL HISTORY**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Constitutional Systems**  Fever Yes  No  Fatigue Yes  No  Weight loss Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Musculoskeletal**  Arthritis Yes  No  (circle one) osteo, rheumatoid or psoriatic  Muscle/Joint/Back Pain Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ear, Nose, Mouth, Throat**  Hearing Loss Yes  No  Sinus Congestion/Disorders Yes  No  Dry Throat/Mouth Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Integumentary**  Rosacea Yes  No  Shingles Yes  No  Skin Cancer Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cardiovascular**  Atrial Fibrillation Yes  No  Heart Disease Yes  No  Hypertension (high blood pressure) Yes  No  High Cholesterol Yes  No  Heart Attack Yes  No  Stroke/TIA Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Neurological**  Multiple Sclerosis Yes  No  Convulsions/Seizures Yes  No  Frequent Headaches Yes  No  Restless Leg Syndrome Yes  No  Head Injury Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Respiratory**  Asthma Yes  No  Emphysema or COPD (circle one) Yes  No  Shortness of Breath Yes  No  Sleep Apnea Yes  No  Snoring Yes  No  COVID-19 Yes  No | **Allergic/Immunologic**  Seasonal Allergies Yes  No  Lupus Yes  No  Sarcoidosis Yes  No  HIV/AIDS Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Gastrointestinal**  Crohn’s Yes  No  Irritable Bowel Syndrome Yes  No  Stomach/Intestinal Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Psychiatric**  Memory Loss Yes  No  Depression Yes  No  Anxiety Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Genitourinary**  Bladder Yes  No  Kidney Disease Yes  No  Prostate Enlargement/Disorder Yes  No  STDs Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Endocrine**  Diabetes Yes  No  (circle one) Type I or II  Thyroid Yes  No  (circle one) Hypothyroid or Hyperthyroid  Pituitary Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hematological/Lymphatic**  Anemia Yes  No  Sickle Cell or Trait Yes  No  Swelling Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cancer**  Cancer Yes  No  Please Specify Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Maternity**  Pregnant or Nursing Yes  No |

|  |  |
| --- | --- |
| **Eye Diseases/History**  Amblyopia (lazy eye) Yes  No Dry Eye Syndrome Yes  No  Blindness Yes  No Eye/Lid Injury Yes  No  Cataract Yes  No Glaucoma Yes  No  Color Blindness Yes  No Macular Degeneration Yes  No  Diabetic Retinopathy Yes  No Retinal Detachment Yes  No  Strabismus (eye alignment) Yes  No Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EYE SURGERY/TRAUMA:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do you currently use any eye drops?** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do you wear:** **Glasses?** Yes  No If **YES**, how old is your present pair of lenses? \_\_\_\_\_\_\_\_\_\_\_\_  **Contact lenses?** Yes  No If **YES**, do you over wear or sleep in your lenses? Yes  No | |
| **Current Eye Symptoms**  Loss of Central Vision Yes  No Mucous Discharge Yes  No Eye Pain or Soreness Yes  No  Blurred Vision Yes  No Redness Yes  No Itching Yes  No  Burning Yes  No Double Vision Yes  No Dryness Yes  No  Distorted Vision (halos) Yes  No Flashes/Floaters Yes  No Glare/Light Sensitivity Yes  No  Loss of Side Vision Yes  No Excess Tearing Yes  No Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chronic Infection of Eye/Lid Yes  No Sandy/Gritty Feeling Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Social History**  Job (Occupation) Yes  No  Do You Drive? Yes  No  **Have you had the Pneumococcal (Pneumonia) Vaccine?**  Yes  No  **If YES, WHEN?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Tobacco Use?** Yes  No  **If YES, How Much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(Includes Smoking, Chew, Vape)**  **Do You Drink Alcohol?** ☐Yes ☐ No  **If YES, How Much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Do You Use Recreational Drugs? ☐Yes ☐ No |

**List any Surgeries and/or hospitalizations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:** Do any medical or eye diseases run in your family (**blood-related**)?

If YES, please note relationship.

Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataracts, early onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Reconciliation**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy (Name/Address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (Name/Address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you take, including vitamins and supplements:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **How Often** | **Last Dose**  **(Office Use Only)** |
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Please list any allergies you have:

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| --- | --- |
| **Allergy** | **Reaction** |
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**Patient** **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(For Surgery Center Use Only)* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Updated**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient Initials) (Date) (Time) **Patient Label**

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**AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION**

I request that Vision Eye Group communicate with me, or the designated individual(s) identified below, concerning my medical information, including billing. This authorization will remain valid for one year from the date signed. I understand I have the right to revoke this authorization at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name (Printed) Date of Birth**

**RELEASED TO:** (Please list any family members, friends, or physicians we can talk to on your behalf)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Telephone Relationship

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Name Telephone Relationship

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Name Telephone Relationship

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Name Telephone Relationship

**HEALTH CARE SURROGACY**

Is there a person that is authorized to make health care decisions on your behalf if you are unable?

Yes. If yes, please list authorized person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date