Sergeant Bluff EyeCare

Today's Date: _____ ☐ **Male** ☐ **Female** ☐ **Other**

First/Last Name: _____ **MI:**_____ **DOB:** ___/___/____

Address: _____ **SSN:** _____

City/State: _____ **Zip:** _____ **Home Phone:** _____

Email: _____ **Cell Phone:** _____

Employer: _____ ***Do you wish to receive text reminders?*** Y N

Emplyed/School Status:
☐ Full Time ☐ Part Time ☐ Not Employeed ☐ Retired ☐ Active Miltary

Marital Status:
☐ Single ☐ Divorced ☐ Married ☐ Widowed

Prefered Language: _____

Race:
☐ American Indian ☐ Asian ☐ African American ☐ Decline to Specify ☐ European ☐ Hispanic ☐ Native Hawaiian/Pasific Islander ☐ White

Ethnicity:
☐ Patient Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Care Physician: _____

Spouse Information

Spouse's Name: _____ DOB: ____/____/_____
Address (if different than above): _____
City/State/Zip: _____ SSN: _____
Employer:_____ Cell Phone: _____

Parent Informations (If a Minor)

Father's **Name**: _____ **DOB:** ____/____/_____
Address (if different than above): _____
City/State/Zip: _____ **SSN:** _____
Employer:_____ **Cell Phone:** _____

Mother' **s Name**: _____ **DOB:** ____/____/_____
Address (if different than above): _____
City/State/Zip: _____ **SSN:** _____
Employer:_____ **Cell Phone**: _____

Ocular History:

Purpose of today's visit:

- ☐ Blurry Vision
- ☐ Burning
- ☐ Double Vision
- ☐ Dryness
- ☐ Flash of Light
- ☐ Floaters/spots in vision
- ☐ Grittiness
- ☐ Headaches
- ☐ Infection
- ☐ Itchiness
- ☐ Night Vision difficulty
- ☐ Eye pain
- ☐ Tearing
- ☐ Update contact lenses

When was your last eye exam? _____

Do you wear contact lenses? Y N

Have **you** been diagnosed with the following?

- ☐ None
- ☐ Cataracts
- ☐ Corneal abrasion
- ☐ Dry Eye
- ☐ Eye turn/ lazy eye
- ☐ Glaucoma
- ☐ Iritis/ uveitis
- ☐ Macular Degeneration
- ☐ Retinal defect/hole/tear
- ☐ Retinal detachment
- ☐ Other eye disease

Has anyone in your **family** been diagnosed with the following?

- ☐ None
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Other eye diseases

Check Your Vision Insurance

- ☐ VSP
- ☐ Eyemed
- ☐ Spectera
- ☐ Davis
- ☐ Avesis
- ☐ Other: _____

Medical Insurance Information

Medical Insurance: _____

Member ID: _____

Group: _____

Policy Holder's Name if different: _____

Policy Holder's DOB: ___/___/___ **SSN:** _____

Relationship to Patient: _____

Visual Needs Assessment:

Hours of computer usage per day: _____

Hours of outdoor activity per day: _____

Hobbies: _____

_____

How many hours do you read before you experience fatigue? _____

Check if you have:

- ☐ eyestrain
- ☐ neck strain
- ☐ headaches

Who can we thank for your referral to our office?

_____

Current medications & Dose (include OTC & Supplements)

_____

_____

_____

_____

_____

Allergies:_____

_____

_____

List any prior *eye* surgeries & dates if known (e.g. LASIK):

_____

_____

Are you pregnant or nursing? Y N

Do you use cigarettes? Y N

if so, how often? _____

Do you drink alcohol? Y N

if so, how often? _____

Medical History:

Have you ever been diagnosed or treated for any of the following health problems? (If yes, include diagnosis; otherwise, circle N for No & F for family history)

Allergies	Y_____	N	F
Arthritis	Y_____	N	F
Blood/Lymph	Y_____	N	F
Cancer	Y_____	N	F
Cholesterol	Y_____	N	F
Diabetes	Y_____	N	F
Digestive/Gastirc	Y_____	N	F
Ears/Nose/Throat	Y_____	N	F
Endocrine	Y_____	N	F
Fatigue	Y_____	N	F
Fevers	Y_____	N	F
Heart Disease	Y_____	N	F
High Blood Pressure	Y_____	N	F
Immune	Y_____	N	F
integumentary (Skin Disease	Y_____	N	F
Kidney	Y_____	N	F
Musle/Bone	Y_____	N	F
Neurological/Headaches	Y_____	N	F
Psychological	Y_____	N	F
Respiratory	Y_____	N	F
Sinus	Y_____	N	F
Stroke/Seizures	Y_____	N	F
Throat Infections	Y_____	N	F
Thyroid	Y_____	N	F
Unusual Weight Loss/Gain	Y_____	N	F

Notice of Privacy Practices

Sergeant Bluff EyeCare Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review out Notice before signing this Consent. The terms of our Notice may change, and if we change our notice, you may obtain a revised copy by contacting our office. Sergeant Bluff EyeCare provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Sergeant Bluff EyeCare has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Sergeant Bluff EyeCare reserves the right to change the Notice of Privacy Practices.
- You have the right to request how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.
- The patient may revoke this Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.
- Sergeant Bluff EyeCare may condition treatment upon the execution of this Consent.
- By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations.

Date:_____ Signature of Patient or Responsible Party:_____

Signature on File for Insurance

I hereby authorize Sergeant Bluff EyeCare to submit my insurance claims and that payment of authorized insurance benefits (including Medicare benefits) for any services furnished to me, be made on my behalf to Sergeant Bluff EyeCare. I understand that I am responsible for any amount not covered by my insurance(s).

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Date:_____ Signature of Patient or Responsible Party:_____

Signature on File for Insurance

May We release any medical information, includes prescriptions, to family? If so please list who:

_____

Date:_____ Signature of Patient or Responsible Party:_____