HEALTH AND MEDICATION INFORMATION

11-2012

Name DOB: Todays date:

Occupation: Family Dr: Referring Dr:

Home Phone: Work Phone: Cell Phone: Email:

Approximate Height: Weight:

When was your last eye exam? When was your last physical?

Preferred Communication by: Telephone Postal Email Text Gender: Female Male

Do you wear glasses? Y N For distance only Near only Lined Bi focal, Lined Tri focal, No line Progressive

Do You wear Contacts? Y N Soft Disposable Replace lens every : day / 2 wk / month Brand: Rigid CL

Are you interested in wearing contacts? Yes No Have you worn contacts in the past? Y N

Y	N	Past Medical History
		Please check Yes or No
		High Blood Pressure
		Heart Disease
		Elevated Cholesterol
		Diabetes # of yrs
		Lung Disease
		Circulatory Disease
		Thyroid Disease
		Arthritis
		Asthma
		Seizures
		Cancer
		Liver Disease
		HIV Positive / Aids
		Bowel Disease
		Kidney Disease
		Blood Transfusion
		Alzheimers / Dementia
		Psychiatric
		Other

Y	N	Family History
		List relationship, if Grandparent, please note
		maternal Grandmother or ***paternal*** Grandmother
		High Blood Pressure
		Heart Disease
		Elevated Cholesterol
		Diabetes
		Lung Disease
		Circulatory Disease
		Thyroid Disease
		Arthritis
		Asthma
		Seizures
		Cancer
		Liver Disease
		Bowel Disease
		Kidney Disease
		Alzheimers / Dementia
		Psychiatric
		Other

Y	N	Body System Review
		Do you **now** have any of these symptoms?
		Cardiovascular (heart, chestpain)
		Musculoskeletal (arthritis, bone)
		Integumentary (skin)
		Gastrointestinal (stomach / bowel)
		Psychiatric (Depression…)
		Endocrine (Diabetes, Thyroid)
		Ears, Nose, Throat Mouth (dry mouth, Chronic cough, sinus)
		Respiratory (Asthma, Lung, Sleep Apnea)
		Genitourinary (bladder, sexually transmitted disease)
		Neurological (headaches, migrains, seizures)
		Constitutional (fever, weight loss, etc.)
		Hematologic / Lymphatic (anemia, bleeding problem)
		Allergic / Immunologic hayfever, HIV, Aids)

		Past Ocular History
		Eye Injury
		Eye Surgery
		Glaucoma
		Cataracts
		Retinal Disease
		Crossed or Lazy eye

		Family History
		Glaucoma
		Cataracts
		Retinal Disease
		Crossed or Lazy eye

		Social History
		Are you pregnant?
		Do you smoke?
		Have you ever smoked?
		Do you use alcohol?
		seldom / frequently (circle one)

Please list any Eye drops that you use:

Please list any Allergies to Medications:

Please list any Medications/ Drugs and the condition you are taking them for.		**Please list any surgeries and date**	
Name of Drug	Condition	Surgery	Date

Insurance Information

PATIENT INFORMATION				Today's Date:		
Last Name:	First Name:	M.I.	Nickname:	Gender:	Age:	Birthdate:
Telephone: (Home)	(Work)	(Cell)		SSN:		
Address:		City:		State:	Zip Code:	
Preferred Language:	Race: American Indian/Alaska Native Asian African American Hispanic Native Hawaiian/Other Pacific Islands White					
Communication Preference: E-Mail Telephone Text						
Employer/School:		Marital Status:		E-Mail Address:		
Employment Status:		Occupation:		Referred to this office by:		

SPOUSE'S INFORMATION (if applicable)			
Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
Telephone: (Home)	(Cell)	SSN:	
Employer:		Occupation:	
Employer's Address & Phone:			

PARENT/LEGAL GUARDIAN'S BILLING INFORMATION (if applicable)			
Name:			
Address:	City:	State:	Zip Code:
Telephone: (Home)	(Cell)	SSN:	
Employer:		Occupation:	
Employer's Address & Phone:			

INSURANCE INFORMATION	Primary Vision Insurance	Primary Medical Insurance
Name of Insurance Company:		
Name of Primary Insured:		
Primary Insured SSN:		
Primary Insured Birth Date:		
Primary Insured ID Number:		
Primary Insured Group Number:		

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

I certify that the above is correct. I agree that if the account is not paid the cost of collections, including all attorney fees and court costs incurred will be included as part of my financial obligation.

Signature

SUNSHINE
EYE CLINIC

Optometrists
Dr. Bary M. Brown Dr. Ronald W. Keeling
Dr. Brenda A. Carrell Dr. Chris H. Boschen

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Larimore, Baker, Brown and Associates, Inc., dba Sunshine Eye Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- A means by which payment for services can be made and
- A means by which we may communicate to you by mail when you have materials ready for pick up

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand the organization reserves the right to change its notice and practices and will provide a copy of any revised notice. I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Larimore, Baker, Brown, and Associates, Inc., dba Sunshine Eye Clinic, unless Sunshine Eye Clinic agrees to the request in writing.

I understand that for convenience or necessity I would like my health information available to the following friends or family members:

_____ _____

_____ _____

I fully understand and accept the terms of this contract.

_____ _____

Patient Signature Date