EYE & VISION CLINICS, SC – PATIENT INFORMATION

Date:_____

Last Name:_____ **First Name:**_____ **MI:**_____

Preferred Name/Nickname:_____ **Maiden Name:**_____

Date of Birth:_____ **Social Security Number:**_____

Address:_____

_____

Telephone: _____ (Home) □ preferred

_____ (Work) □ preferred

_____ (Cell) □ preferred

Email:_____

Marital Status:_____ **Spouse's Name:**_____

Minor Children's Names/Ages:_____

Insured Name:_____ **Insured DOB:**_____ **Insured Employer:**_____

Patient Employer:_____ **Patient Occupation:**_____

(For Children) School:_____ **Grade:**_____

(For Children) Parent/Guardian:_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□Native Hawaiian or Other Pacific Islander □ White □ Other □ Declined

How did you find out about our office?

□ Friend/Relative/Coworker (Name_____)

□ Health Care Provider □ Insurance □ Website □ Other_____

Date of last eye exam_____ Clinic Name/Location_____

Have you ever been diagnosed with any of the following conditions?

□ Cataract □ Age related macular degeneration □ Glaucoma □ Diabetes □ Diabetic Retinopathy

□ Dry Eye □ Eye infection, inflammation, or allergy □ Floaters/Flashes of light □ Iritis or Uveitis

□ Retina defects or degeneration □ Other_____

OVER →

EYE & VISION CLINICS, SC

DAVID R. DUFECK, O.D. MATTHEW L. NELSON, O.D.

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CONSENT FOR SERVICES

I consent to evaluation and treatment services provided to me by Eye & Vision Clinics. I understand that I may need additional testing, treatment, and visits if directed. I understand that it is my responsibility to schedule and keep future appointments and to follow instructions given to me by my doctor.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have (received/been offered) a copy of the Notice of Privacy Practices for Eye & Vision Clinics, SC. This notice describes how this office may use and disclose my protected health information, and rights I may have regarding my protected health information.

PAYMENT AGREEMENT

I understand that I must provide accurate insurance information at each appointment in order for Eye & Vision Clinics to file a claim on my behalf. I authorize insurance payments directly to my provider for services provided. I understand that I am responsible for the full payment if the services are not covered by my insurance, I do not have insurance coverage, or my provider is not contracted with my insurance. I agree that I am responsible for copayments and charges placed towards the deductible, as well as any balance due after insurance payment is received. I will pay any outstanding balances upon receipt of a statement. I also understand that for any glasses or contact lens orders, payment must be made in full before the orders will be dispensed.

Signature **X** ____ Date_________________

Date: _____

Name: _____DOB: _____

Email Address: _____

Do you wear glasses/contact lenses for:

☐ distance (driving, television, sports events)

☐ intermediate (computer, shopping, sheet music)

☐ near (reading, needlepoint)

Are you satisfied with the clarity of your vision with current glasses/contacts?

☐ Yes

☐ No, please explain_____

Are you experiencing any of the following: (check all that apply)

☐ Blurred vision	☐ Redness	☐ Burning	☐ Itching
☐ Eye strain	☐ Eye pain	☐ Tearing	☐ Discharge
☐ Headaches	☐ Flashes	☐ Floaters	☐ Double vision
☐ Severe sensitivity to lights	☐ Bothersome glare		☐ Dry Eye
☐ Poor night vision	☐ Total loss of vision		

☐ Other_____

Please list ALL current medications, supplements, and vitamins (including dosage) Or Attach List

_____

_____

_____

_____

Primary Care Physician/Clinic: _____Date of last exam____

Interests: (check all that apply)

☐ New eyeglasses	☐ Reading glasses
☐ Prescription sunglasses	☐ Safety glasses
☐ Non-prescription sunglasses	☐ New supply of contact lenses
☐ Computer glasses	☐ New fitting of contact lenses
☐ Sports (including hunting, swimming, motorcycle)	

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Review of Systems (<u>check all that apply</u>):

(Constitution) ☐ developmental disabilities ☐ cancer ☐ fatigue Syndrome

(ENT) ☐ hearing loss ☐ sinusitis ☐ dry mouth ☐ laryngitis

(Neurologic) ☐ multiple sclerosis ☐ epilepsy ☐ cerebral palsy ☐ tumor ☐ stoke/CVA ☐ migraine, ☐ autism spectrum disorder

(Psychiatric) ☐ depression ☐ attention deficit ☐ anxiety ☐ bipolar disorder

(Cardiovascular) ☐ **hypertension** ☐ stroke/CVA ☐ heart disease ☐ vascular disease ☐ congestive heart failure

(Respiratory) ☐ cigarette smoker ☐ asthma ☐ bronchitis ☐ emphysema ☐ chronic obstruction ☐ sleep apnea

(GI) ☐ Crohn's ☐ colitis ☐ ulcer ☐ acid reflux ☐ celiac disease

(GU) ☐ kidney disease ☐ prostate disease/cancer ☐ STD (herpetic/Chlamydia), ☐ benign prostate hypertrophy ☐ herpes ☐ Chlamydia ☐ **pregnant/nursing (_____delivery date)**

(Musculoskeletal) ☐ osteoarthritis ☐ arthritis ☐ fibromyalgia ☐ muscular dystrophy ☐ ankylosing spondylitis ☐ osteoporosis ☐ gout

(Integumentary) ☐ eczema ☐ rosacea ☐ psoriasis ☐ herpes simplex (cold sores) ☐ herpes zoster (shingles)

(Endocrine) ☐ **type 2 diabetes mellitus** ☐ **type 1 diabetes mellitus** ☐ thyroid dysfunction ☐ hormonal dysfunction

(Hematic/Lymphatic) ☐ anemia ☐ large volume blood loss ☐ ulcer ☐ **high cholesterol**

(Allergy/Immune) ☐ **drug allergies** ☐ **environmental allergies** ☐ rheumatoid arthritis ☐ lupus, ☐ Sjogren's syndrome

<u>Family</u> Medical History: ***(check all that apply)***

☐ Cancer ☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Hyperthyroidism ☐ Hypothyroidism

<u>Family</u> Ocular History: ***(check all that apply)***

☐ Amblyopia ☐ Cataract ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Strabismus

Social History:

- Alcohol Use: ☐ Never ☐ Occasional ☐ Daily
- Tobacco Use: □ Never □ Previous □ Current
  - Tobacco Type_____ How often_____