

PATIENT INFORMATION AND MEDICAL HISTORY

NAME: _____ NICKNAME: _____ DATE OF BIRTH: ___/___/___

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ SSN: _____

EMAIL: _____ PREFERRED CONTACT: HOME CELL EMAIL

GENDER: MALE FEMALE ETHNICITY: HISPANIC NOT HISPANIC DECLINED TO ANSWER

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER _____

SPECIAL NEEDS: HEARING IMPAIRED TRANSLATOR WHEEL CHAIR OTHER _____

RACE: WHITE AMERICAN INDIAN ASIAN AFRICAN AMERICAN OTHER DECLINE TO ANSWER

LANGUAGE: ENGLISH SPANISH FRENCH ITALIAN RUSSIAN OTHER _____

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION:

HOLDER: SELF SPOUSE PARENT GUARDIAN OTHER _____

NAME: _____ GENDER: MALE FEMALE PHONE: _____

INSURANCE NAME: _____ DATE OF BIRTH: ___/___/___ SSN: _____

PLEASE PROVIDE ALL INSURANCE INFORMATION AT FRONT DESK

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

OPTOMAP RETINAL IMAGING

Southern Colorado Eye Care Associates recommends Optomap Retinal Imaging for all of our patients every year. The Optomap allows us (and you) a view into your eyes without the use of dilation drops. Digital scanning technology allows for early detection of glaucoma, macular degeneration, diabetes, hypertension, and ocular cancer. These diseases typically have no associated symptoms in their early stages.

Vision insurance will NOT cover this screening procedure.

-The fee for this screening is \$35.00 per adult and \$20.00 per patients under the age of 18.

-Please indicate your preference: I prefer to have Optomap imaging I prefer dilation of my pupils (no additional fee)

-When re-using own frame, Southern Colorado Eye Care Associates' staff is not responsible for any damage or breakage during the glazing process of putting new lenses into the frame. _____ (initial)

-If you have never worn contacts and will have to be taught how to insert and remove contacts, It is \$50.00 _____ (initial).

-If you have worn contacts before and know what brand of contacts you are in or are a previous patient. It is \$25.00 _____ (initial).

HIPPA NOTICE OF PRIVACY PRACTICES

Our office adheres to federal and state privacy regulations. A copy of the complete privacy policy will be made upon your request. The privacy policy describes how medical information about you made be used and disclosed and how you can get access to this information

INSURANCE COVERAGE WAIVER

By signing below, you understand that today's visit may or may not be covered by your insurance. You understand that Southern Colorado Eye Care Associates will submit claims to your insurance, as a courtesy, for review and subsequent reimbursement. You understand that you will be liable for **any and all** charges incurred for this visit if your insurance denies payment for any tests and/or procedures. We will only bill insurance presented at the time of service. Insurance presented after services will not be accepted.

SIGNATURE: _____ DATE: ___/___/___

HIPPA/INSURANCE ACKNOWLEDGMENT

MEDICATIONS (including eye drops):

NO MEDICATIONS

MEDICATION ALLERGIES:

NO KNOWN MEDICATION ALLERGIES

HEIGHT: _____ feet _____ inches WIEGHT: _____ pounds LAST KNOWN BLOOD PRESSURE: _____ / _____

SYSTEMIC ILLNESS (Please mark all that apply):

No History of Illness

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neurology Disorder | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Eczema | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other _____ |

OCULAR HISTORY AND SURGERIES (Please mark all that apply):

Ocular Health Unremarkable

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Floaters / Flashes | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Pterygium | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Pain / Strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> PRK / LASIK / RK | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Farsighted |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Strabismus (Eye turn) | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Nearsighted |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Eye Redness | <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Other _____ |

FAMILY HISTORY (parents, child, sibling):

Family History Unknown

- | | | | | |
|------------------------------------|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Keratoconus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Strabismus | _____ |

SOCIAL HISTORY: ALCOHOL USE: YES NO RECREATIONAL DRUG USE: YES, TYPE: _____ NO

TOBACCO USE: SOME DAY SMOKER EVERYDAY SMOKER FORMER SMOKER NEVER SMOKER