

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	Y	N	Family History	Y	N	Body System Review
		Please check Yes or No			List relationship, if Grandparent, please note			Do you now have any of these symptoms?
		High Blood Pressure			<i>maternal</i> Grandmother or <i>paternal</i> Grandmother			Cardiovascular (heart, chestpain)
		Heart Disease			High Blood Pressure			Musculoskeletal (arthritis, bone)
		Elevated Cholesterol			Heart Disease			Integumentary (skin)
		Diabetes # of yrs			Elevated Cholesterol			Gastrointestinal (stomach / bowel)
		Lung Disease			Diabetes			Psychiatric (Depression...)
		Circulatory Disease			Lung Disease			Endocrine (Diabetes, Thyroid)
		Thyroid Disease			Circulatory Disease			Ears, Nose, Throat Mouth
		Arthritis			Thyroid Disease			(dry mouth, Chronic cough, sinus)
		Asthma			Arthritis			Respiratory
		Seizures			Asthma			(Asthma, Lung, Sleep Apnea)
		Cancer			Seizures			Genitourinary
		Liver Disease			Cancer			(bladder, sexually transmitted disease)
		HIV Positive / Aids			Liver Disease			Neurological
		Bowel Disease			Bowel Disease			(headaches, migrains, seizures)
		Kidney Disease			Kidney Disease			Constitutional
		Blood Transfusion			Alzheimers / Dementia			(fever, weight loss, etc.)
		Alzheimers / Dementia			Psychiatric			Hematologic / Lymphatic
		Psychiatric			Other			(anemia, bleeding problem)
		Other						Allergic / Immunologic
								hayfever, HIV, Aids)
		Past Ocular History			Family History			Social History
		Eye Injury			Glaucoma			Are you pregnant?
		Eye Surgery			Cataracts			Do you smoke?
		Glaucoma			Retinal Disease			Have you ever smoked?
		Cataracts			Crossed or Lazy eye			Do you use alcohol?
		Retinal Disease						seldom / frequently (circle one)
		Crossed or Lazy eye						

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



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.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF FINANTIAL RESPONSIBILITY

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 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: _____ Date: _____