PATIENT HISTORY FORM

Date: ______________ Name: ____ Nickname: __________________

First Name Last Name

Age:__________ Date of Birth: __________________ Guardian Name (for minors): ______________________________________

Phone: ____ Sex: M / F Last 4 SSN: ______________________________

Address: ____

Street Address Apt/Suite/Unit City State Zip Code

EMAIL: ____ Referred By: _____________________________

Vision Insurance: VSP / Spectera / Superior / Davis / NVA / Eyemed / CHP+ / Medicaid / Medicare / None / Other: _______________

Medical Insurance: _________________ Occupation: ________________________________ Employer: _______________________

HIPAA NOTICE OF PRIVACY POLICIES

I acknowledge that I can request a copy of LONGMONT EYECARE, PLLC'S Notice of Privacy Practices (available from our front desk). The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

____ __________________

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS / INSURANCE BILLING RELEASE

I authorize the exchange of information necessary for treatment, payment, and healthcare operations, including the processing of insurance claims to LONGMONT EYECARE, PLLC) and authorize to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days old are subject to collections, and there will be a service charge for any bounced checks. All co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time services are rendered.

____ __________________

Signature of Patient or Authorized Representative Date

HEALTH RELATED COMMUNICATIONS AND REMINDERS BY MOBILE TEXTING AND EMAIL

I permit LONGMONT EYECARE, PLLC to communicate and remind me about my health-related issues and appointments by text and email.

____ __________________

Signature of Patient or Authorized Representative Date

CONTACT LENS CONSENT

The contact lens fitting/evaluation fee provides you with the diagnostic contact lenses needed for your prescription to be finalized. All follow-up appointments related to your contact lenses (up to one month) are included in this fee. Professional service fees, including the examination charges and contact lens fitting fee, are non-refundable. Per federal law, contact lens prescriptions expire one year from the date of the fitting.

____ __________________

Signature of Patient or Authorized Representative Date

RETINAL EXAM: DILATION OR OPTOS

Dilation: Drops are used to enlarge the pupil, allowing the doctor to see a more complete view of the retina. The drops will cause light sensitivity and blurred vision, especially up close for approximately 2-4 hours. This will add approximately 30 minutes to your exam. It is not recommended to drive while your eyes are dilated.

Optomap: Optos is a fast, painless, and comfortable digital imaging of the retina. The Optos allows your doctor to confirm your retinal health, or discover signs of abnormalities. It provides a permanent record of your retina that can be compared and reviewed at next year's exam. Drops are not required in most cases. This is the Doctor's preferred method.

PLEASE CHOOSE ONE OR LEAVE BLANK AND DISCUSS WITH THE DR.

Please note: THERE IS AN ADDITIONAL CHARGE OF $24 FOR THE OPTOMAP RETINAL EXAM

☐ **DILATION** **OR** ☐ **OPTOMAP**

FLIP OVER AND COMPLETE BACK SIDE

PATIENT MEDICAL HISTORY

Doctor Reviewed_________________________ Date__________________

Ocular History: Please Circle **Date of Last Eye Exam:**_____________________________

Cataracts	Dry Eyes	Floaters	Lazy Eye/Strabisums	Pterygium
Color Deficiency	Eye Surgery	Glaucoma	Macular Degeneration	Redness
Diabetic Retinopathy	Flashes	Keratoconus	Ocular Injury	Retinal Detachment
Double Vision	Other**:** ____			

Ocular Surgery History:____

Do you wear Glasses? Yes / No Use: Distance / Near / Computer

Do you wear Contacts? Yes / No Brand: _____________________________

General Health History: Please Circle **Date of Last Physical Exam:** _________________________

Arthritis	HIV/AIDS	Respiratory Disease	Nursing/Pregnant
Autoimmune Disorder	Heart Disease	Hypertension	Seasonal Allergies
Asthma	High Cholesterol	Multiple Sclerosis	Thyroid Disease
Cancer:_________________________________		Other:______________________________________	

Diabetes: Date of Diagnosis:_______________ Type I / Type II Last HGA1c:_________________

Medications:____

____

____

Allergies:____

Surgeries: ____

Primary Doctor/City:____

Pharmacy/City:____

Smoking Status: Never Smoker Former Smoker Occasional Every Day Years Smoked:

☐ I prefer to discuss my medical history directly with my doctor.

Family History: Please Circle:

Cataracts	Relationship: ___________________	Cancer	Relationship: ________________________
Glaucoma	Relationship: ___________________	Diabetes	Relationship: ________________________
Macular Degeneration	Relationship: ___________________	Hypertension	Relationship: ________________________
Retinal Detachment	Relationship: ___________________	Autoimmune Disease	Relationship: ________________________
Keratoconus	Relationship: ___________________	Other:_________________	Relationship: ________________________

All information disclosed on this form is stricly confidential and conforms to HIPAA regulations