

Randolph County Eye Care Center

Dr. Jenna Gongola and Dr. Kevin Lambert

Patient Name: _____ Sex M/F: _____

SSN: _____ DOB: _____ Race: _____

Marital Status: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name/If child, Parent's Name: _____

Patient's Employer or School: _____ Occupation/Grade: _____

Name of Person Responsible for Account: _____ Employed By: _____

Date of Last Eye Exam: _____ Doctor/Facility: _____

Primary Care Medical Doctor/Facility: _____

Year of Last Physical Exam: _____ Phone Number of Primary Care: _____

Please Indicate any of the following ocular problems you have had:

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Other	Any Injuries to the Eye? <i>(if so, please include the dates)</i>
<input type="checkbox"/> Glaucoma	Any Eye Surgeries? <i>(if so, please include the dates)</i>	
<input type="checkbox"/> Lazy Eye		
<input type="checkbox"/> Macular Degeneration		
<input type="checkbox"/> Retinal Detachments		

If Female: Are you Pregnant: _____ **Have you had any history of seizures:** _____

Please check conditions which you have or are experiencing:

<input type="checkbox"/> Abdominal	<input type="checkbox"/> Fever	<input type="checkbox"/> Stroke
<input type="checkbox"/> Liver Failure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Over-active
<input type="checkbox"/> Acne	<input type="checkbox"/> Headaches	<input type="checkbox"/> Carotid Artery Stenosis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Lupus	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid Under Active
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Cold/Heat Intolerance
<input type="checkbox"/> Easy Bruising/Bleeding	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Confusion

Wheezing
 Depression
 Kidney Failure
 Joint Swelling

Diabetes (If so, what type):

Cancer (If so, what type):

Hepatitis (If so, what type):

Other:

Please indicate when you last had any of the following preventative test or services:
 (If selected, please put the date or year it was completed)

Blood Sugar _____

Blood Pressure _____

Cholesterol _____

Carotid Artery _____

Please list any surgeries you have had, as well as where and when you've had them:

Surgery	Hospital/Facility	Date

Please select the information which applies best to you (If indicated, please fill out the rest):

Tobacco:

Habits: Never Past Current

If you selected never, move to the next substance:

Year started _____ if stopped, year stopped _____

Type: Smoke Chew

Occurrences: _____ Packs/Day _____ Cans/Week

Alcohol:

Habits: Never Past Current

If you selected never, move to the next substance:

Occurrences: _____ Drinks/Day or _____ Drinks/Week or _____ Drinks/Month

Caffeine:

Habits: Never Past Current

If you selected never, move to the next substance:

Type: Coffee Tea Soda

Occurrences: _____ Cans/Day or _____ Cups/Day

Please select if you are on any of the following medications:

- Topamax:
Dose: _____
- Elmiron:
Dose: _____
- Flomax:
Dose: _____
- Prednisone:
Dose: _____
- Flonase:
Dose: _____
- Tamoxifem:
Dose: _____
- Hydroxychloroquine (Plaquenil) or Chloroquine:
If taken, fill out the HCQ Questionnaire on last page
Dose: _____

Please list all other medications you're on:

*(include vitamins & over the counter medicine)
If more room is needed, bring/attach a copy of the medications.
If none, state "none"; if bringing a list, state "list"*

Please select or list any major illness that you know of in your family members:

(Family members include Mother, Father, Brother, Sister, Grandparents, or Children)

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Retinal Detachments |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Thyroid Disease |

Other: _____

Are you allergic to Latex? _____

List any other allergies or intolerances to drugs or other substances you might have:

Patient Signature (or Parent/Guardian): _____ Date: _____

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Voluntary Consent Form

Randolph County Eye Care Center P.C.
P.O. Box 1489 Elkins, WV 26241
(304) 636-3887
Fax: (304) 636-0538

Consent to use or disclose health information for treatment, payment and health care operations.

Patient Name: _____

Patient Date of Birth: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office.

We have a comprehensive *Notice of Privacy Practices* that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this *Consent Form*. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care answers provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or discloses made for the purposes of treatment, payment, or health care operations, but as described in the *Notice of Privacy Practices*, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and health care operation.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient or Beneficiary Name (Print)

Ins. Policy Number/Medicare

1. **INSURANCE/MEDICARE:** I request that payment of authorized Medicare or other Insurance benefits be made on my behalf to Randolph County Eye Care, P.C. (RCECC), for services furnished me by RCECC, I authorize any holder of medical information about me to release to my insurance company or the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

2. **RELEASE OF INFORMATION:** RCECC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable or under contract to RCECC for reimbursement for services rendered, and (2) any health care provider for continued patient care RCECC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of the authorization may be used in place of the original.

3. **NON-COVERED SERVICES:** understand that RCECC's contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.

4. **FINANCIAL AGREEMENT:** agree that in return for the services provided to the patient by RCECC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to RCECC for payment. If an account IS sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to RCECC, [if co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to RCECC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient or Beneficiary (Signature)

Date

HCQ Questionnaire

Only complete if you are taking Hydroxychloroquine or Chloroquine

Age: _____ Weight (important for medication dosage): _____ Date of Birth: _____

Referring /Specialty Dr. _____ Last seen: _____

Are you currently under the care of an ophthalmologist or optometrist?

___ Yes ___ No If yes, please include name and date last seen _____

Have you ever had ocular baseline testing done?

___ Yes ___ No ___ Unsure

Which medication are you taking that you are being monitored for ocular toxicity?

___ Chloroquine ___ Hydroxychloroquine ___ Other: _____

Dosage: _____ Duration: _____

Why are you taking this medication?

___ Lupus ___ Rheumatoid Arthritis ___ Other: _____

Are you currently being treated or monitored for kidney disease?

___ Yes ___ No

Any recent major weight loss?

___ Yes ___ No

Are you also using the medication Tamoxifen (commonly used to prevent breast cancer)?

___ Yes ___ No

Any changes in your vision or color vision?

___ Yes ___ No If yes, please explain: _____

Any changes seen with your at home Amsler grid testing?

___ Yes ___ No ___ Unsure If yes, please attach Amsler with explanation _____