eye-brain connection

Date: _____

Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. _____ / _____ / ____ ☐Male ☐Female
Last First MI

Address: _____ / _____ / _____ / _____
Street City State Zip

Birthdate: ____/____/_____ How did you hear about us? _____

Home phone (____)_____ Work phone (____)_____Ext.____Cell (____)_____

E-mail address (IMPORTANT): _____

Dr. Trinka ☐ has my permission/ ☐ does not have my permission to send me a monthly health email.

In case of emergency, contact: _____ Phone: (____)_____ Relationship: _____

Marital status: ☐Single ☐Married Social Security #: _____

Occupation: _____ Employer: _____

Vision Insurance Information:

Insurance Company: _____

Member's Name: _____ Member's ID#: _____

Primary Care Physician: _____ Phone: _____

Primary Care Physician Address: _____

Present Medical Condition/Symptoms: _____

_____

_____

Present Rx Medications: _____

Present Over-the-Counter medications: _____

Present Supplements: _____

Frequent Activities: Work related: _____

Recreational: _____

Why are you here to see us today? _____

PLEASE READ CAREFULLY

INFORMED CONSENT, AUTHORIZATION, DISCLAIMER AND RELEASE: I understand and agree that all services provided by Dr. Trinka shall be charged directly to me and that I am responsible for final payment of any such services regardless of insurance coverage, including, without limitation, Medicare coverage. I hereby authorize the release by Dr. Trinka of all information and records deemed necessary to secure payment or to benefit my health. I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE.

Signature: _____ Date: _____

eye-brain connection
Symptom Questionnaire

Name _____ **Date** ____/____/____
Birthdate: _____ **Grade in school this year:** _____
Do you wear glasses or contact lenses: _____
Please place a check in the column that most accurately describes your current vision with your glasses or contacts on.

	Never	Seldom	Occasionally	Frequently	Always
I get a headache when I do near work.					
I use a finger or marker to keep my place when I read.					
I see double, or cover or close an eye while I read.					
Words move, wiggle, float or jump when I read.					
I get dizzy or nauseated when I do near work.					
I tilt my head when I read or when I am talking to people.					
I get close to the page when I read or write.					
I lose my place while reading.					
I am slow copying from the chalkboard.					
I skip words or lines while reading.					
I have trouble understanding what I read.					
I read small words backwards. (was-saw)					
I get tired or sleepy while reading.					
My eyes get tired, itchy, watery or burn when I read.					
Print in a book looks blurry.					
I guess at words.					
I can only read for ____ hours.	+2 hrs.	2 hrs.	1 hour	30 minutes	15 minutes
I read for pleasure.	Always	Frequently	Occasionally	Seldom	Never

PLEASE READ CAREFULLY INFORMED CONSENT, AUTHORIZATION, DISCLAIMER AND RELEASE:
I understand and agree that all services and materials provided by Dr. Trinka shall be charged directly to me and that **I am responsible for final payment of any such services and materials <u>regardless of insurance coverage.</u>** I hereby authorize the release by Dr. Trinka of all information and records deemed necessary to secure payment or to benefit my health.
I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE.

PARENT/GUARDIAN Signature: _____

Dr. Terence A. Trinka, O.D., CN
eye-brain connection
7steps2health

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.
Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.
For questions concerning our Notice of Privacy Policies, please contact Dr. Trinka.

Patient's Consent

Name: _____

Signature: _____

I, _____ have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.
If a personal representative on behalf of the patient signs this consent, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

Patient's Revocation
By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this consent revocation, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____