

# PATIENT CONSENT FORM

Dr. Howard B. Stromwasser, O.D  
210 Suburban Dr.  
Newark, DE 19711

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name : \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT INFORMATION**  
**DR. HOWARD B. STROMWASSER**  
**OPTOMETRIST**

Dr. Howard B. Stromwasser and staff will strive to make your visit today a pleasant experience. Please assist us by completing this form.

Today's Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Parent's Name \_\_\_\_\_  
(last) (first) (MI) (If Child)  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Campus address and phone \_\_\_\_\_  
(school and grade if child)

Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Name and # of Vision Insurance \_\_\_\_\_

Name and # of Major Medical Insurance \_\_\_\_\_

**Other Information**

What is the reason for today's visit? \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

What is the name of your family doctor? \_\_\_\_\_

Name and age of family members: Husband/Wife \_\_\_\_\_

Sons \_\_\_\_\_ Daughters \_\_\_\_\_

Method of Payment: Check \_\_\_ Cash \_\_\_ MC \_\_\_ Visa \_\_\_ Disc \_\_\_

**Non-Medicare Authorization**

Our office policy is to collect payment at time of visit or a co-payment if insurance covers services/ Please fill out personal payment section of your insurance form and submit it to receptionist before your examination. You are responsible for any problem concerning payment for visit or our office policy. I have read and understand the above policy. I hereby authorize Dr. Howard B. Stromwasser to release all information necessary to secure the payment of benefits. I authorize to use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

**Medicare Authorization**

I request the payment of the authorized benefits be made to Dr. Howard B. Stromwasser for any services furnished to me by the physicians/supplier/provider of care. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

\_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Date

**WELCOME TO OUR OFFICE**

Reason for today's visit: \_\_\_\_\_

If you wear glasses, when do you wear them? \_\_\_\_\_

Please answer the following questions by circling a number:

Please circle Yes (Y) or No (N):

Never 0 Slight 1 Moderate 2 Severe 3  
 Gritty or sandy sensation? 0 1 2 3  
 Pain or soreness? 0 1 2 3  
 Fluctuating vision? 0 1 2 3  
 Occasional tearing? 0 1 2 3  
 Blurred vision while reading? 0 1 2 3  
 Discomfort in windy conditions? 0 1 2 3  
 Discomfort in air-conditioned areas? 0 1 2 3  
 Itching? 0 1 2 3

Distance vision blurry without glasses Y N  
 Distance vision blurry with glasses Y N  
 Near vision blurry without glasses Y N  
 Near vision blurry with glasses Y N  
 Headaches Y N  
 Sinus problems Y N  
 Flashes of light Y N  
 Floaters Y N  
 Loss of vision (blackout) Y N  
 Eye pain Y N  
 Double vision Y N  
 Eye injuries Y N  
 Eye surgeries Y N  
 Eyes cross Y N  
 Lazy eye Y N  
 Other (please explain) Y N

	You	Family
Diabetes	Y N	Y N
High blood pressure	Y N	Y N
Heart problems	Y N	Y N
Breathing problems	Y N	Y N
Cataracts	Y N	Y N
Glaucoma	Y N	Y N
Macular degeneration	Y N	Y N
Cancer	Y N	Y N

Please list all medications and the reasons you are taking them:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you consume alcohol? Y N If yes, how many drinks per week? \_\_\_\_\_  
 Do you use recreational drugs? Y N If yes, how many times per week? \_\_\_\_\_  
 Do you consume tobacco products? Y N If yes, how many packs per day? \_\_\_\_\_  
 Do you have any drug or environmental allergies? Y N If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_