# 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:

| | 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 |

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

| | |
|---|---|
| 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 _____

**DR. HOWARD B. STROMWASSER**

**OPTOMETRIST**

# VISUAL FIELDS EXAMINATION

A highly specific computerized instrument allows us to provide a more thorough medical analysis of your eyes. Our HUMPHREY VISUAL FIELDS ANALYZER electronically measures retinal function and sensitivity to light. This measurement can assist us in the early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy, and retinal detachments.

We strongly recommend that all of our patients receive the screening version of this exam. It is especially important for people who have:

1) Headaches
2) See spots or flashes of light
3) A history of Diabetes
4) A history of high blood pressure
5) Circulatory problems
6) A strong eyeglass prescription
7) Reached age of 35

There is an additional charge of $20.00 for the screening exam.

Please check the appropriate line below and sign at the bottom.

_____ I DO want the visual field exam

_____ I DO NOT want the visual field exam

PATIENT'S SIGNATURE: _____

DATE: _____