# Welcome to our Office....

Thank you for choosing our practice for your eyecare needs. Please fill out the following information. You will not be asked to fill out this same information on subsequent visits. If you have questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient name _____ Date of birth _____

Address _____ City _____ State _____ ZIP Code_____

Home phone _____ Other phone _____

Social Security Number _____ Email Address _____

Whom may we thank for referring you to us? _____

Method of Payment ( ) Cash/Check ( ) Medicare
( ) Medicaid ( ) VSP
( ) Insurance _____

Many insurances request that we have your signature on file to bill for vision benefits. Please read the following paragraph and sign below so that we will bill your vision insurance.

*Note:* Even if you do not currently have vision insurance, please go ahead and sign below so that we have your signature on file should you have insurance in the future.

I request that payment of authorized benefits be made either to myself or on my behalf to Brian D. McCollom, O.D. for any services furnished me by Dr. McCollom. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9of the HCFA – 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, or-insurance, and noncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

Name_____ Date_____

Personal Medical History (ROS)

*** Constitutional**

[Y/N] Developmental Disabilities
[Y/N] Cancer
[Y/N] Fatigue Syndrome
[Y/N] Other

*** Ears, Nose, Throat, Mouth**

[Y/N] Hearing Loss
[Y/N] Sinusitis
[Y/N] Dry Mouth
[Y/N] Laryngitis

*** Neurological**

[Y/N] Multiple Sclerosis
[Y/N] Epilepsy
[Y/N] Cerebral Palsy
[Y/N] Migraine

*** Psychiatric**

[Y/N] Depression
[Y/N] Attention Deficit
[Y/N] Anxiety
[Y/N] Bipolar

*** Cardiovascular**

[Y/N] Hypertension
[Y/N] Stroke/CVA
[Y/N] Heart Disease
[Y/N] Vascular Disease
[Y/N] Congestive Heart Failure

*** Respiratory**

[Y/N] Asthma
[Y/N] Bronchitis
[Y/N] Emphysema
[Y/N] COPD
[Y/N] Sleep Apnea

*** Gastrointestinal**

[Y/N] Crohn's
[Y/N] Colitis
[Y/N] Ulcer
[Y/N] Acid Reflux/Heart Burn
[Y/N] Celiac Disease

*** Genitourinary**

[Y/N] Kidney Disease
[Y/N] Prostate Disease/Cancer
[Y/N] STD
[Y/N] Benign Prostate Hypertrophy
[Y/N] Pregnant
[Y/N] Nursing

*** Musculoskeletal**

[Y/N] Arthritis
[Y/N] Osteoarthritis
[Y/N] Fibromyalgia
[Y/N] Muscular Dystrophy
[Y/N] Osteoporosis
[Y/N] Gout

*** Integumentary**

[Y/N] Eczema
[Y/N] Rosacea
[Y/N] Psoriasis
[Y/N] Herpes Simplex/Cold Sores
[Y/N] Herpes Zoster/Shingles

*** Endocrine**

[Y/N] Type 2 Diabetes
[Y/N] Type 1 Diabetes
[Y/N] Thyroid Dysfunction
[Y/N] Hormonal Dysfunction

*** Hematologic/Lymphatic**

[Y/N] Anemia
[Y/N] Hypercholesteremia

*** Allergic/Immunologic**

[Y/N] Drug Allergies
[Y/N] Environmental Allergies
[Y/N] Rheumatoid Arthritis
[Y/N] Lupus
[Y/N] Sjogren's Syndrome

Please list any medications you are currently using:
**Medication/Dosage/Frequency**

_____
_____
_____
_____
_____

Are you allergic to any medications? [Y/N] If yes, which medications?

_____

**Past Ocular History**
When was your last eye exam?_____ Dr. name?_____
Do you currently wear glasses [Y/N] or contacts [Y/N]? If so, what type?_____
_____

**Please check if you have any of the following:**
[ ] Glaucoma [ ] Glaucoma Suspect [ ] Cataracts [ ] Surgery [ ] Macular Degeneration
[ ] Strabismus [ ] Amblyopia [ ] Retinal Degeneration/Hole Detachment [ ] Keratoconus
[ ] Dry Eye [ ] Nystagmus

**Immediate Family Medical History: Please Answer Who Has It**
[ ] Hypertension_____ [ ] Diabetes_____ [ ] Cancer _____
[ ] Glaucoma _____[ ] Cataracts _____ [ ] Macular Degeneration _____

**Social History**
Do you:
[Y/N] Smoke
[Y/N] Drink
[Y/N] Smokeless Tobacco

**Personal History**
Occupation_____
Hobbies_____
Hours/day computer use_____

## NOTICE OF PRIVACY PRACTICES

This notice of privacy practices describes how we may use or disclose your health information and how you can get access to such information. A full copy of our privacy practices is available upon request.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Brian D. McCollom, O.D. Notice of Privacy Practices.

Date _____ Patient Name_____ Signature_____