EYE CENTER OF NEW ALBANY

Michael D. Ware, OD
Allison B. Norwood, OD

PATIENT INFORMATION

Date: _____

SS#: _____

Patient Name: _____ (First Name) _____ (Middle Name) _____ (Last Name)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home / Cell Phone _____ **Work Phone** _____

E-mail _____

Sex : ☐ M ☐ F **Age:** _____ **Birthdate:** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partner

Occupation _____

Patient Employer _____

Spouse/Parent Name _____ **Spouse/Parent Birthdate** _____ **Spouse/Parent Phone Number** _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____

Whom may we thank for referring you? _____

REVIEW of SYSTEMS

Only check those items you are experiencing

CONSTITUTIONAL			**EARS, NOSE AND THROAT**		
Fever	☐ Yes	☐ No	Allergies / Hay Fever	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No	Sinus Congestion	☐ Yes	☐ No
INTEGUMENTARY			Runny Nose	☐ Yes	☐ No
Skin	☐ Yes	☐ No	Post-Nasal Drip	☐ Yes	☐ No
NEUROLOGICAL			Chronic Cough	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Dry Throat / Mouth	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Ear Pain or Infection	☐ Yes	☐ No
EYES			Hearing Aids	☐ Yes	☐ No
Loss of Vision	☐ Yes	☐ No	Deaf	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	**VASCULAR, CARDIOVASCULAR**		
Distorted Vision / Halos	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Loss of Side Vision	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Dryness	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Mucous Discharge	☐ Yes	☐ No	**GASTROINTESTINAL**		
Redness	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Itching	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Burning	☐ Yes	☐ No	**GENITOURINARY**		
Foreign Body Sensation	☐ Yes	☐ No	Gonads / Kidneys / Bladder	☐ Yes	☐ No
Excess Tearing	☐ Yes	☐ No	**BONES / JOINTS / MUSCLES**		
Glare / Light Sensitivity	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Eye Pain or Soreness	☐ Yes	☐ No	Other Arthritis	☐ Yes	☐ No
Chronic Infection of Eye or Lid	☐ Yes	☐ No	Muscle Pain	☐ Yes	☐ No
Styes or Chalazion	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Flashes	☐ Yes	☐ No	**LYMPHATIC / HEMATOLOGICAL**		
Floaters in Vision	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Tired Eyes	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Color Blind	☐ Yes	☐ No			

REVIEW of SYSTEMS (CONTINUE)

Only check those items you are experiencing

RESPIRATORY

- Asthma ☐ Yes ☐ No
- Chronic Bronchitis ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

ENDOCRINE

- Thyroid / Other Glands ☐ Yes ☐ No

ALLERGIC, IMMUNOLOGIC ☐ Yes ☐ No

PSYCHIATRIC ☐ Yes ☐ No

If you have any other condition not listed above, please explain:

Are you pregnant? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have any allergies To Medications? ☐ Yes ☐ No

If Yes, Explain _____

List any medications you take (including oral contraceptives, asprin, over the counter medications and home remedies)

EYE HEALTH HISTORY

List Any of the following that you have had:

Prominent Eyes	☐ Yes ☐ No	Crossed Eyes	☐ Yes ☐ No	Lazy eye	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Eye Injury	☐ Yes ☐ No	Drooping Eyes	☐ Yes ☐ No

Name of last eye doctor _____

Date of last eye exam _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving

Do you wear contacts? ☐ Yes ☐ No

Type _____ **Hours/Day** _____

Are they comfortable? ☐ Yes ☐ No

Describe any problems you are currently having with your eyes:

List all eye injuries and eye surgeries you have had:

NOTICE OF PRIVACY PRACTICES: I have been shown or offered a copy of the privacy policies.

AUTHORIZATION TO RELEASE INFORMATION: I hearby authorize Eye Center of New Albany, LLC to release any medical or incidental information that may be necessary for medical benefit in processing applications for financial benefit. This includes, but is not limited to my insurance company, rehabilitation services, social security administration and worker's compensation.

CONSENT FOR TREATMENT: I hearby authorize Eye Center of New Albany, LLC to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Patient / Guardian Signature **Date**

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Eye Center of New Albany, LLC will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information. This disclosure will remain in effect until revoked by me or by me guardian (if a minor).

Contact Name:	Relationship:	Phone Number:
Contact Name:	Relationship:	Phone Number:
Contact Name:	Relationship:	Phone Number:

CONSENT FOR DILATION:

Dilating the pupils consist of instilling drops into the eyes in order to make the opening in the colored part of our eyes larger and thus enabling an easier look into the back of the eye to check for ocular disease. Side effects are usually limited to blurred vision at near and sensitivity to sunlight lasting for about 3-6 hours. If you are nursing or pregnant, dilation is not recommended.

_____ I understand and agree to have my eyes dilated today

_____ I understand and do not wish to have my eyes dilated today.

Patient / Guardian Signature **Date**

CONTACT LENS AGREEMENT:

I, _____, agree and understand that contact lenses are a medical device and should be used only as instructed by my doctor. Failure to do so could result in a decrease or loss of vision. I also understand that I have a 30 day period from the date of my eye exam in which I will not have to pay for problems involving my contact lenses. I will be responsible for charges incurred after this 30 day period. I also understand that no refunds will be issued for the time and effort that my doctor put into fitting me into contact lenses.

Patient / Guardian Signature **Date**

Returning Patients:

I have reviewed the patient information and medical history and have noted any changes:

Patient's Signature _____ **Date:** _____

Patient's Signature _____ **Date:** _____

Patient's Signature _____ **Date:** _____

Patient's Signature _____ **Date:** _____

INSURANCE INFORMATION

Vision Insurance: _____

Subscriber Name: _____

Subscriber ID#: _____ **Subscriber Birth Date:** _____

Primary Medical Insurance _____

Subscriber Name: _____

Subscriber ID#: _____ **Subscriber Birth Date:** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ **and assign directly to Eye Center of New Albany, LLC all insurance benefits, if any, otherwise payable to me**

Name of Insurance Company(ies)

for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor/clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in effect until revoked by me in writing.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Date **Relationship to Patient**

MEDICARE / MEDIGAP AUTHORIZATION:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Eye Center of New Albany, LLC for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers fro Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____

Patient/Guardian Signature Date

ADVANCED BENEFICIARY NOTICE:

Medicare and some private insurance companies do not consider refractions (test used to determine the prescription required for your glasses) and contact lens fitting to be a covered service. Therefore, I am responsible for payment of the refraction portion of my exam. Medicare considers refractions to be "not medically necessary" and, therefore, does not cover refractions. Your insurance company may not consider refractions to be medically necessary, either.

_____

Patient/Guardian Signature Date