NAME……...**DATE**……..……
ADDRESS……..……**CITY**…..……..……...**ZIP**…..……..
AGE..……**BIRTHDATE**……...……..…..**PHONE**……..
E-MAIL……..**CELL**……..……
REFERRED BY……...**OCCUPATION**……..……

MEDICAL HISTORY: DO YOU HAVE, OR HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING (CIRCLE ANSWER)?

	PATIENT	FAMILY	EXPLANATION
ALLERGIES……	YES NO ?	YES NO ?	……
ARTHRITIS……	YES NO ?	YES NO ?	……
ASTHMA……	YES NO ?	YES NO ?	……
BLINDNESS……	YES NO ?	YES NO ?	……
BRONCHITIS……	YES NO ?	YES NO ?	……
CANCER……	YES NO ?	YES NO ?	……
CATARACT……	YES NO ?	YES NO ?	……
COLOR BLINDNESS……	YES NO ?	YES NO ?	……
CROSSED/LAZY EYE…..	YES NO ?	YES NO ?	……
DIABETES……	YES NO ?	YES NO ?	……
DOUBLE VISION……	YES NO ?	YES NO ?	……
DRY EYE……	YES NO ?	YES NO ?	……
EMPHESEMA……	YES NO ?	YES NO ?	……
EYE/HEAD INJURY……	YES NO ?	YES NO ?	……
FLOATERS……	YES NO ?	YES NO ?	……
GLAUCOMA……	YES NO ?	YES NO ?	……
HEADACHES/MIGRAINES	YES NO ?	YES NO ?	……
HEART DISEASE……	YES NO ?	YES NO ?	……
HEPATITIS……	YES NO ?	YES NO ?	……
HIGH BLOOD PRESSURE	YES NO ?	YES NO ?	……
KIDNEY DISEASE……	YES NO ?	YES NO ?	……
LIGHT FLASHES……	YES NO ?	YES NO ?	……
RETINAL DISEASE……	YES NO ?	YES NO ?	……
THYROID DISEASE……	YES NO ?	YES NO ?	……
TUBERCULOSIS……	YES NO ?	YES NO ?	……
OTHER……	……	……	……

HAVE YOU EVER BEEN INFECTED WITH ANY SEXUALLY TRANSMITTED DISEASE?
YES NO……
EMERGENCY CONTACT:……
FAMILY PHYSICIAN:……
LIST MEDICATIONS:……
ANY SURGERIES/HOSPITALIZATIONS:……
ARE YOU PREGNANT? YES NO N/A NURSING? YES NO N/A

CONTINUED ON BACK

HIPAA: I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT THIS OFFICE WILL NOT SHARE MY PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS WITHOUT MY PERMISSION, UNLESS REQUIRED BY LAW.

SIGNATURE……..……..……..DATE……

INSURANCE INFORMATION:

NAME OF INSURED:……BIRTHDATE……..
SSN……RELATIONSHIP TO PATIENT……
PRIMARY INSURANCE COMPANY & ID#.....
SECONDARY INSURANCE COMPANY & ID#.....

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO DR. MICHAEL HAYES FOR ANY CURRENT OR FUTURE SERVICES HE PROVIDES ME.
I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE……..DATE……..……

THIS OFFICE IS PLEASED TO ACCEPT YOUR INSURANCE FOR COVERED BENEFITS, BUT UNTIL YOUR CLAIM IS SUBMITTED AND APPROVED, THERE IS NO GUARANTEE OF PAYMENT TO US. WE THEREFORE MUST ASK YOU TO ASSUME RESPONSIBILITY FOR ANY UNPAID BALANCES.
I ACCEPT RESPONSIBILITY FOR ANY BALANCES NOT PAID BY MY INSURANCE.

SIGNATURE……..DATE……..……

PUPIL DILATION: PUPIL DILATION IS RECOMMENDED TO ALLOW A BETTER VIEW OF THE RETINA AND OTHER OCULAR STRUCTURES AND CAN AID IN THE DETECTION OF MANY OCULAR ABNORMALITIES. YOUR VISION WILL BE BLURRED FOR SOME TIME AFTER DILATION, AND IT IS SUGGESTED THAT YOU NOT DRIVE FOR THREE HOURS. YOUR INSURANCE MAY OR MAY NOT COVER THIS PROCEDURE, AND IF IT IS NOT COVERED, YOU WILL BE RESPONSIBLE FOR PAYMENT FOR THIS SERVICE.

O YES, I WOULD LIKE TO BE DILATED.
O NO, I DO NOT WANT TO BE DILATED.
O NO, I DO NOT WANT TO BE DILATED BUT WILL RETURN FOR DILATION.

SIGNATURE……..DATE……..……