Welcome to Catawba Eye Care

Dr. Scott Kriessler
Optometrist
(419) 960-2020

3978 Harbor Light Landing
Port Clinton, OH 43452

Patient Information: CONFIDENTIAL **Visit us at www.catawbaeyecare.com**

Mr, Mrs, Ms, Miss, Dr

Name:_____ Birth Date:____/____/____ Date:_____
Last First Middle Initial

Address:_____ Home Phone ( )_____

City, State, Zip_____ Work Phone ( )_____

Employer/Job Description_____ Cell Phone ( )_____

Emergency Contact/Number_____ Relationship_____

Email_____ Whom May we thank for referring you_____

Name of Insurance_____ Policy Holder Name/S.S#_____

Name of Primary Care Physician_____ Last Physical Exam_____

Preferred Language:_____ **Race:**_____ **Ethnicity:** Hispanic/Non-Hispanic (circle one) **Identifies as:** Male/Female/Other (circle one)

Do you have, or have you ever had any problems in the following areas? Please circle

Constitutional: (Development Disabilities, Cancer, Fatigue Syndrome)

Ears, Nose, Mouth, Throat: (Hearing Loss, Sinusitis, Dry Throat/Mouth, Laryngitis)

Neurological: (MS, Epilepsy, Cerebral Palsy, Tumor, Migraines, Stroke/CVA)

Psychiatric: (Depression, Attention Deficit, Anxiety Bipolar Disorder)

Cardiovascular: (Hypertension, Stroke/CVA, Heart Attack, Vascular Disease, Congestive Heart Failure)

Respiratory: (Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea)

Gastrointestinal: (Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease)

Genitourinary: (Kidneys, Prostate, STD-Herpetic, Chlamydia, Pregnant, Nursing)

Muscles/Skeletal: (Arthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout)

Integumentary: (Eczema, Rosacea, Psoriasis, Herpes Skin Lesions)

Endocrine: (Diabetes Type I, Type II, Thyroid, Hormone Dysfunctions)

Lymphatic/Hematologic: (Anemia, History of Large Blood Loss, Cholesterol)

Allergic/Immunologic: (Allergies (Environmental), RA, Lupus, Sjogren 's syndrome)

Are you allergic to any Medications: Yes/No (List): _____

Do you give us permission to look up any of the medications you are using? ☐ **Yes** ☐ **No** ☐ **I have a med. list**

List Current Medications: _____

_____

Current Height:_____ **Current Weight:**_____ **Smoking:** Yes / No / Former **Alcohol use:** Yes / No

Circle any of the following you have had: crossed eyes, lazy eyes, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, injury, or eye surgery (type):_____

Family History of Eye disease: Glaucoma, Blindness, Cataracts, Macular Degeneration, Keratoconus: None

Are you planning to get new eyeglasses today? Yes No Only if Rx changes

Over, Please

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Are Contact Lenses part of your examination today? Yes No Only if Rx changes

(Involves fitting and evaluation of contact lenses, additional fee's apply, depending on lens type)

Are you interested in finding out more about Laser Vision Correction? Yes No

Hobbies: Please circle (We have many specialty eyewear options to enhance your vision)

Fishing Golf Boating Shooting Skiing Diving Flying Biking Swimming Photography

We must have all insurance information before today's examination. Many insurance companies require prior authorization. If we do not have all necessary information, you are responsible for payment, and we will file for your reimbursement.

Please Read Carefully:
I understand that my medical records are confidential, and by signing this consent form I am allowing my medical information to be released upon an insurance carrier request, for the purpose of Health Care Operations. (Including, but not limited to, provider review functions, claims payment, and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. If revoked, all fees for service will be private pay going forward.

For additional information on our Patient Confidentiality Policy, please refer to our website at www.fyeo.net. We update the Patient Confidentiality Policy periodically and reserve the right to make changes as required. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment in full for all services rendered on my behalf, or on the behalf of my dependents. I authorize and request my insurance company to pay my eye doctor directly.

If before or during a wellness/comprehensive exam, the doctor finds a medical concern, then it will be considered a medical/sick visit and billed accordingly. I accept the terms and consent to treatment being given to me by the doctor.

Advanced Beneficiary Notice: There are some tests that are needed to monitor for eye diseases- If your doctor feels that it is necessary to have these tests performed, the test may not be covered by your insurance carrier. If reviewed with you by the doctor, there is a fee for this test of $50 for the Retinal Photos, $100 for the Threshold Visual Field and $60 for the OCT measurements for your macula or optic nerve and if you elect, there is a charge of $15 for the Antioxidant Scan.

The fees for the examination are good for 30 days after the initial exam. Problems with glasses or contact lens prescriptions must be addressed within this time or additional fees will be incurred. After 30 days, you will be charged a fee per visit to solve any prescription problems. All materials must be picked up within 60 days or you will forfeit your deposit. Any outstanding balances are subject to an interest charge of 2% per month. Returned checks are subject to a $40 fee, and if a collection agency has to be used to recover the original check amount, the fee is $80.

I declare that I have read, understand the above information and have answered the questions accurately. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient (or parent if minor)_____

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

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Over, Please