PATIENT INFORMATION AND MEDICAL HISTORY

NAME:_____ **NICKNAME:**_____ **DATE OF BIRTH:**____/____/_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **SSN:**_____

EMAIL:_____ **PREFERRED CONTACT:** ☐ HOME ☐ CELL ☐ EMAIL

GENDER: ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ HISPANIC ☐ NOT HISPANIC ☐ DECLINED TO ANSWER

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER_____

SPECIAL NEEDS: ☐ HEARING IMPAIRED ☐ TRANSLATOR ☐ WHEEL CHAIR ☐ OTHER_____

RACE: ☐ WHITE ☐ AMERICAN INDIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ OTHER ☐ DECLINE TO ANSWER

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ FRENCH ☐ ITALIAN ☐ RUSSIAN ☐ OTHER_____

PRIMARY CARE PHYSICIAN:_____ **PHARMACY:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

INSURANCE INFORMATION:

HOLDER: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER_____

NAME:_____ **GENDER:** ☐ MALE ☐ FEMALE **PHONE:**_____

INSURANCE NAME:_____ **DATE OF BIRTH:** ____/____/_____ **SSN:**_____

PLEASE PROVIDE ALL INSURANCE INFORMATION AT FRONT DESK

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

OPTOMAP RETINAL IMAGING

Southern Colorado Eye Care recommends Optomap Retinal Imaging for all of our patients every year. The Optomap allows us (and you) a view into your eyes without the use of dilation drops. Digital scanning technology allows for early detection of glaucoma, macular degeneration, diabetes, hypertension, and ocular cancer. These diseases typically have no associated symptoms in their early stages.

Vision insurance will NOT cover this screening procedure.

-The fee for this screening is **$35.00** per adult and **$20.00** per patients under the age of 18.

-Please indicate your preference: ☐ **I prefer to have Optomap imaging** ☐ **I prefer dilation of my pupils (no additional fee)**

FRAME AND CONTACT LENS POLCY

-When re-using your own frame, Southern Colorado Eye Care's staff is not responsible for any damage or breakage during the glazing process of putting new lenses into the frame._____(initial)
-If you are a new patient, or have never worn contacts (and will require insertion and removal training). It is $50.00_____(initial).
-If you have worn contacts before and know what brand of contacts you are in or are a previous patient. It is $25.00_____(initial).

HIPPA NOTICE OF PRIVACY PRACTICES

Our office adheres to federal and state privacy regulations. A copy of the complete privacy policy will be made upon your request. The privacy policy describes how medical information about you made be used and disclosed and how you can get access to this information

INSURANCE COVERAGE WAIVER

By signing below, you understand that today's visit may or may not be covered by your insurance. You understand that Southern Colorado Eye Care will submit claims to your insurance, as a courtesy, for review and subsequent reimbursement. You understand that you will be liable for **any and all** charges incurred for this visit if your insurance denies payment for any tests and/or procedures. We will only bill insurance presented at the time of service. Insurance presented after services will not be accepted.

SIGNATURE:_____ **DATE:**_____/_____/_____

HIPPA/INSURANCE ACKNOWLEDGMENT

MEDICATIONS (including eye drops): ☐ NO MEDICATIONS

_____

_____

_____

MEDICATION ALLERGIES: ☐ NO KNOWN MEDICATION ALLERGIES

_____

_____

HEIGHT:_____feet_____inches **WEIGHT:** _____pounds **LAST KNOWN BLOOD PRESSURE:**_____/_____

SYSTEMIC ILLNESS (Please mark all that apply)**:** ☐ **No History of Illness**

☐ ADHD	☐ Bleeding Disorder	☐ Headache/Migraine	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Anemia	☐ Cancer	☐ Hearing Loss	☐ Kidney Disease	☐ Seasonal Allergies
☐ Anxiety	☐ Depression	☐ Heart Disease	☐ Liver Disease	☐ Skin Cancer
☐ Arrhythmia	☐ Diabetes	☐ Hepatitis	☐ Lupus	☐ Stroke
☐ Arthritis	☐ Eczema	☐ High Blood Pressure	☐ Neurology Disorder	☐ Thyroid Disease
☐ Asthma/COPD	☐ Fibromyalgia	☐ High Cholesterol	☐ PTSD	☐ Other_____

OCULAR HISTORY AND SURGERIES (Please mark all that apply)**:** ☐ **Ocular Health Unremarkable**

☐ Amblyopia (Lazy Eye)	☐ Diabetic Retinopathy	☐ Eye Redness	☐ Glaucoma	☐ Pterygium
☐ Astigmatism	☐ Double Vision	☐ Eye Strain/Pain	☐ Keratoconus	☐ Retinal Detachment
☐ Cataract Surgery	☐ Dry Eyes	☐ Farsighted	☐ Macular Degeneration	☐ Strabismus (Eye turn)
☐ Cataracts	☐ Eye Infection	☐ Floaters / Flashes	☐ Nearsighted	☐ Watery Eyes
☐ Corneal Transplant	☐ Eye Injury	☐ Glasses/Contacts	☐ PRK / LASIK / RK	☐ Other_____

FAMILY HISTORY (parents, child, sibling)**:** ☐ **Family History Unknown**

☐ Amblyopia	☐ Cancer	☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Arthritis	☐ Cataracts	☐ High Blood Pressure	☐ Macular Degeneration	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Retinal Detachment	☐ Other_____
☐ Blindness	☐ Glaucoma	☐ Keratoconus	☐ Strabismus	_____

SOCIAL HISTORY: **ALCOHOL USE**: ☐ YES ☐ NO **RECREATIONAL DRUG USE**: ☐ YES, TYPE:_____ ☐ NO

TOBBACCO USE: ☐ SOME DAY SMOKER ☐ EVERYDAY SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKER