My Optics of Little Silver Medical History

Name: _____ Today's Date _____

Address: _____
street town zip code

Phone: (Home) _____ (cell) _____ Email: _____

Date of Birth: _____

Last Eye Exam: _____

Reason For Today's Visit (Routine check up, contacts, blurry vision): _____

Do You Wear Glasses, Contacts, Both or None: _____

If you wear contacts, what type (brand) and what strength: _____

Please List any Medications you are currently taking: _____

_____

Please list any allergies (medication, seasonal and other): _____

Do **YOU** have any of the following:

	Yes	No	How long
GENERAL: *fever, weight loss, weight gain, fatigue?*			
EAR, NOSE, THROAT: *allergies, sinus, cough, dry mouth/throat*			
CARDIOVASCULAR: *high BP, heart surgery, vascular disease*			
RESPIRATORY: *asthma, bronchitis, emphysema, COPD*			
KIDNEY, BLADDER: *kidney stones, frequent urination*			
MUSCLES, BONES, JONES: *arthritis, joint pains, head or neck injury*			
SKIN: *growths, rashes, acne*			
NEUROLOGICAL: *headaches, migraines, seizures*			
PSYCHIATRIC: *depression, anxiety, insomnia*			
ENDOCRINE: *thyroid, diabetes*			
BLOOD/LYMPH: *anemia, cholesterol, bleeding problems*			
ALLERGIC/IMMUNOLGIC: *seasonal allergies, rheumatoid, lupus, autoimmune disease*			

	Yes	No
Headaches		
Double Vision		
Flashes		
Floaters		
Loss of Vision		
Blurred Vision		
Loss of Side Vision		
Dry Eye		
Tearing		
Itchy Eyes		
Red Eyes		
Sensitivity to Lights		
Eye Pain		
Discharge from Eyes		
Surgery to Eyes		
Injury to Eyes		

Do you have **FAMILY HISTORY** of:

	Yes	No	Who?
Glaucoma			
Macular Degeneration			
Cataracts			
Blindness			
Strabismus (eye turn)			
Retinal detachment or disease			
High Blood pressure			
Diabetes			
Thyroid Disease			
Cancer			
Other			

Please Sign : _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payer (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature _____

Print Name _____

Relationship to Patient _____

Date _____

My Optics of Little Silver

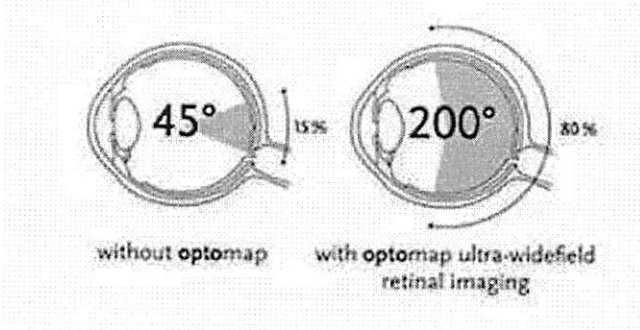
optomap®
Retinal Exam

We are excited to offer the latest technology available to evaluate the health of our patient's eyes

The Optos Daytona Plus provides an unequaled 200 degree view of your retina in a high-resolution, high-contrast digital image. This comprehensive view gives our doctors the opportunity to identify and follow peripheral retinal pathology much more easily. In **many** cases, we may **now avoid the strong dilating drops during the exam.**

Vision Threatening conditions possibly detected with an optomap include:

- Macular Degeneration
- Glaucoma
- Retinal Tears or Detachments
- Ocular melanoa/tumors
- Diabetes
- High Blood Pressure



Benefits of an Optos Scan include:

- No other retinal exam gives you a more extensive single-view scan.
- This scan takes only seconds to perform
- It does NOT REQUIRE DILATING drops
- It is PAINLESS and WILL NOT MAKE YOUR VISION BLURRY afterwards
- This scan becomes a part of your permanent record and enables your Doctor to make important comparisions at future exams.

An Optomap scan is a valuable tool in evaluating the health of your eyes. We feel strongly that it should be performed annually. The cost for the Optomap scan is $35 and may not be covered by your insurance unless there is pathology detected.

The **optomap**® Retinal Exam is fast, easy, and comfortable.

☐ I DO want the procedure performed.

☐ I DO NOT want the procedure performed. I would prefer a regular dilation.

_____ _____
Signature Date

_____
Print name

Insurance Information

PATIENT INFORMATION: **DATE:**_____

Patient's Name: _____ M or F

Patient's Date of Birth: _____ **Best Contact Number:** _____

Patient's Address: _____

_____

PRIMARY MEDICAL INSURANCE:

Name of INSURANCE: _____

ID #: _____ **Patient's relationship to member:** o Self o Spouse o Child o Other

Member's Name: _____

Member's Date of Birth: _____

Member's Address (if different than patient's)_____

_____

Member's Employer:_____

_____

PRIMARY VISION INSURANCE:

Name of INSURANCE: _____

ID #: _____ **SS#** _____

Relationship to Insured o Self o Spouse o Child o Other

Member's Name: _____

Member's Date of Birth: _____

Member's Address (if different than patient's)_____

_____

***** MOST VISION INSURANCES ARE SEPARATE FROM MEDICAL INSURANCES. Providing us with just your medical insurance information is often not enough to find out who covers your ROUTINE eye examination and materials (glasses and contact lenses). It is your responsibility to know you vision plan and provide us with the name and ID number. Please sign that you acknowledge this.**

Please sign: _____

TURN OVER FOR SECONDARY INSURANCE INORMATION

SECONDARY INSURANCE oMEDICAL o VISION

Name of INSURANCE: _____

ID #: _____ SS# _____

Patient's relationship to member: o Self o Spouse o Child o Other

Member's Name: _____

Member's Date of Birth: _____

Member's Address (if different than patient's)_____

_____

TERTIARY INSURANCE: oMEDICAL oVISION

Name of INSURANCE: _____

ID #: _____ SS# _____

Patient's relationship to member: o Self o Spouse o Child o Other

Member's Name: _____

Member's Date of Birth: _____

Member's Address (if different than patient's)_____

_____

I AM AWARE THAT IF FOR ANY REASON THIS CLAIM IS DENIED BY MY INSURANCE AND THE INSURANCE DOES NOT PAY, I AM LIABLE FOR CHARGES FOR SERVICES RENDERED

Patient (Guardian) signature_____