San Luis Valley Eye Care Patient Intake Form

Last:_____ First:_____ MI_____

Address:_____

_____

Tel: (_____)_____ Type: Home / Work / Cell

Email:_____

Date of Birth:_____ Age:_____

Ocular History:

Purpose of today's visit:

- ❑ Annual Visit
- ❑ Blurry Vision
- ❑ Burning
- ❑ Double vision
- ❑ Dryness
- ❑ Flash of light
- ❑ Floaters/spots in vision
- ❑ Grittiness
- ❑ Headaches
- ❑ Infection
- ❑ Itchiness
- ❑ Night vision difficulty
- ❑ Eye pain
- ❑ Tearing
- ❑ Update contact lenses

When was your last eye exam? _____

Do you wear contact lenses? Y N

Have **you** been diagnosed with the following?

- ❑ Cataracts
- ❑ Corneal abrasion
- ❑ Dry Eye
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Injury
- ❑ Iritis/uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal defect/hole/tear
- ❑ Retinal detachment
- ❑ Other eye diseases

Has anyone in your **family** been diagnosed with the following?

- ❑ Cataracts
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Iritis/uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal detachment
- ❑ Other eye diseases

Medical/Vision Insurance Information

Circle Type of Insurance: Medical Vision

Name of Insurance:_____

Member ID:_____

Policy Holder's Name if different: _____

Relationship to Patient:_____

Policy Holder DOB:_____/_____/__

Self pay: Yes No

Visual Needs Assessment:

Hours of computer usage per day:_____

Hours of outdoor activity per day:_____

Hobbies:_____

_____

Circle if you have: eyestrain neck strain headaches

Current Medications and Dose (include OTC and supplements)

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

List any prior surgeries and dates if known:

_____

_____

Are you pregnant or nursing? Y N

Do you use cigarettes? Y N **If so, how often?**_____

Do you drink alcohol? Y N **If so, how often?**_____

Medical History:

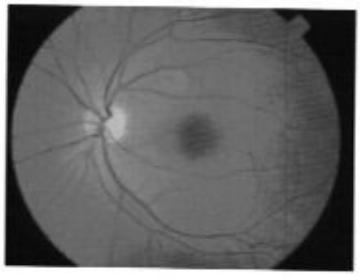
Have you ever been diagnosed or treated for any of the following health problems?(If yes include diagnosis; otherwise, circle N for No and F for family history)

Allergies	Y_____	N	F
Arthritis	Y_____	N	F
Blood/Lymph	Y_____	N	F
Cancer	Y_____	N	F
Cholesterol	Y_____	N	F
Diabetes	Y, Type_____	N	F
Digestive/Gastric	Y_____	N	F
Ears/Nose/Throat	Y_____	N	F
Endocrine	Y_____	N	F
Fatigue	Y_____	N	F
Fevers	Y_____	N	F
Heart Disease	Y_____	N	F
High Blood Pressure	Y_____	N	F
Immune	Y_____	N	F
Integumentary (Skin disease)	Y_____	N	F
Kidney	Y_____	N	F
Muscle or Bone	Y_____	N	F
Neurological/Headaches	Y_____	N	F
Psychological	Y_____	N	F
Respiratory	Y_____	N	F
Sinus	Y_____	N	F
Stroke/Seizures	Y_____	N	F
Throat Infections	Y_____	N	F
Thyroid	Y_____	N	F
Unusual Weight Loss/Gain	Y_____	N	F

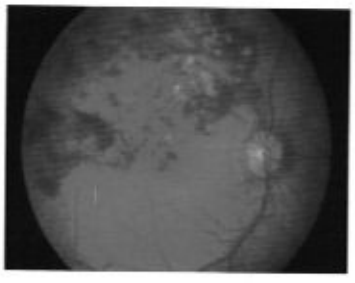
SAN LUIS VALLEY
EYECARE

Digital Retina Photography Consent Form

San Luis Eye Care is pleased to offer Fundus photography as an extension to our comprehensive eye examination. Just as many other health professionals use MRI's, mammograms, and X-rays to aid in diagnosing health conditions, our office provides a comparable level of quality care with digital retina photography. The photo is quick and painless and allows a detailed view of the inner lining of the eye. This high resolution photo enables the doctor to detect early and subtle eye health changes so that treatment may be instituted to preserve your sight. Your retina photo will remain a permanent part of your medical record and will be used to compare with future images to observe for health changes inside your eyes. We can also provide copies of these photos to your medical specialist if referral is needed.



Healthy Eye



Diseased Eye

Dr. Huff recommends that **ALL PATIENTS** have this procedure performed routinely. If you are **40 years and older, we recommend yearly photos**. If you are under 40 years old, every other year is routine, unless otherwise specified by the doctor. It is especially important for people who have:

□ **High Blood Pressure** □ **Diabetes** □ **Headaches** □ **High Cholesterol** □**You are a new patient**
□**If you have a high glasses prescription** □ **If you are seeing flashing light or floaters in your vision**
□**If you have previously had a retinal hole, retinal detachment or other retinal problems**
□ **If you have a Family History of Glaucoma, Macular Degeneration, and/or blindness**
□ **If you have a Family History of Diabetes and or High Blood Pressure**

Generally, vision and medical insurance **DO NOT** pay for screening photos. The charge for this procedure is $25.00. Please indicate your preference by checking the appropriate response below and sign at the bottom of the form. **Yes**_____ I would like to have retina photography performed.

No_____ I decline retina photography at this time.

Signature _____ **DATE**_____

Notice of Privacy Practices Patient Acknowledgement

I have seen this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice,my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such
- ✓ authorization.
- ✓ I understand that my consent can be revoked at any time. Revocation must be made in writing.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of Health and Human Services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Payment Policy:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, Medicaid, private insurance and any other health plans, to San Luis Valley Eye Care. A photocopy of this assignment is to be considered as valid as an originalh hereby authorizesaid assignee to release all information necessary to secure the payment.If my insurance company has not reimbursed SLV Eyecare within 60 days, I may be billed for any services or products that I have received. **All payments including co-payments are due at time of service**. I certify that my responses on this form are accurate to the best of my knowledge.

Signature: _____ Date: _____