

**WELCOME TO OUR OFFICE**

Today's Date: \_\_\_\_\_ (Please Note: If patient is under the age of 18 Parent or Guardian Information Section MUST be filled out.)

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Male/Female \_\_\_\_ SS# \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Are other family members treated here? Y \_\_\_\_\_ N \_\_\_\_\_ If so, Who? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION**

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**INSURANCE INFORMATION****Primary Insurance**

Name of Insurance Co \_\_\_\_\_

Name of Insured \_\_\_\_\_

SS# \_\_\_\_\_

Member ID \_\_\_\_\_

Birth Date of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

**2nd Insurance**

Name of Insurance Co \_\_\_\_\_

Name of Insured \_\_\_\_\_

SS# \_\_\_\_\_

Member ID \_\_\_\_\_

Birth Date of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

**3rd Insurance**

Name of Insurance Co \_\_\_\_\_

Name of Insured \_\_\_\_\_

SS# \_\_\_\_\_

Member ID \_\_\_\_\_

Birth Date of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

**4th Insurance**

Name of Insurance Co \_\_\_\_\_

Name of Insured \_\_\_\_\_

SS# \_\_\_\_\_

Member ID \_\_\_\_\_

Birth Date of Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

## **INSURANCE DISCLAIMER**

**Your insurance will be billed by our office as a courtesy.** Please understand that we do not have control over the coverage you have selected nor when your insurance will pay. Although we accept assignment from many insurance carriers, please remember that **YOU** are responsible for the balance on your account. We allow 90 days from the date of billing for payment from your insurance carrier. If your insurance does not pay within this time frame, then we ask you the patient to make arrangements to pay the outstanding balance on your account.

- I authorize release of information to all my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand my medical records are confidential.
- I understand that by signing this consent form, I am allowing my medical information to be released upon request of insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM**

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the ***Notice of Privacy Practices*** from In Focus Eye Care Center.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority: \_\_\_\_\_

# Medical History

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Medical History

1. Do you have any allergies to medications? If yes please list: \_\_\_\_\_
2. List any medications you take including oral contraceptives, aspirin, over the counter medications and home remedies. If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
3. List all medical conditions you are being treated for: \_\_\_\_\_  
\_\_\_\_\_
4. List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_  
\_\_\_\_\_
5. Are you pregnant and/or nursing? **YES or NO**
6. Do you wear glasses? **YES or NO**
7. Do you wear contacts? **YES or NO**    soft disposable    gas permeable

**General Health Review**    Do you currently, or have you ever had any problems in the following areas.    **YES or NO**  
*Please check all that apply*

### **Constitutional**

- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other \_\_\_\_\_

### **ENT**

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other \_\_\_\_\_

### **Neuro**

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Autism
- ☐ Seizures
- ☐ Other \_\_\_\_\_

### **Psych**

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ PTSD
- ☐ Other \_\_\_\_\_

### **Cardiovascular**

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other \_\_\_\_\_

### **Respiratory**

- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other \_\_\_\_\_

### **Gastrointestinal**

- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other \_\_\_\_\_

### **Gentourinary**

- ☐ Kidney
- ☐ Prostate/Cancer
- ☐ STD Herpetic/Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnancy/Nursing
- ☐ Herpes
- ☐ Other \_\_\_\_\_

### **Musculoskeletal**

- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other \_\_\_\_\_

### **Integumentary**

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold sores
- ☐ Herpes Zoster/Shingles
- ☐ Other \_\_\_\_\_

### **Endocrine**

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other \_\_\_\_\_

### **Hemololgic/Lymphatic**

- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other \_\_\_\_\_

### **Allegeric/Immune**

- ☐ Drug Allergies
- ☐ Enviromental
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other \_\_\_\_\_

**Eyes (Mark all that applies to you )**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Flashes/Floaters in Vision    | <input type="checkbox"/> Dryness/Gritty Feeling  | <input type="checkbox"/> Loss of Vision    |
| <input type="checkbox"/> Amblyopia                     | <input type="checkbox"/> Excess Tearing/Watering | <input type="checkbox"/> Redness           |
| <input type="checkbox"/> Blurred Vision                | <input type="checkbox"/> Eye Pain or Soreness    | <input type="checkbox"/> Retina Detachment |
| <input type="checkbox"/> Chronic Infection of Eye/Lid  | <input type="checkbox"/> Foreign Body Sensation  | <input type="checkbox"/> Lazy Eye          |
| <input type="checkbox"/> Distorted Vision/Halos        | <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Strabismus        |
| <input type="checkbox"/> Double Vision                 | <input type="checkbox"/> Itching/Burning         |  |
| <input type="checkbox"/> Eye Surgery/or Injuries _____ |  |  |
- 

**Family History** Have any family members (Parents, grandparents,siblings, or children)  
ever had any of the following diseases/conditions: (Please Indicate who )

- |   |   |
|---|---|
| <input type="checkbox"/> Amblyopia (Lazy Eye) _____               | <input type="checkbox"/> Glaucoma _____                   |
| <input type="checkbox"/> Arthritis _____                          | <input type="checkbox"/> Heart Disease _____              |
| <input type="checkbox"/> Blindness _____                          | <input type="checkbox"/> High Blood Pressure _____        |
| <input type="checkbox"/> Cancer _____                             | <input type="checkbox"/> Kidney Disease _____             |
| <input type="checkbox"/> Cataract _____                           | <input type="checkbox"/> Macular Detachment/Disease _____ |
| <input type="checkbox"/> Crossed Eyes _____                       | <input type="checkbox"/> Retinal Detachment/Disease _____ |
| <input type="checkbox"/> Diabetes _____                           | <input type="checkbox"/> Thyroid Disease _____            |
| <input type="checkbox"/> Advance Retinal Disease (Disorder) _____ | <input type="checkbox"/> Other _____                      |

**Social History**

This information is kept confidential. If you prefer, you may discuss with the doctor.

- Do you use tobacco Products? **YES or NO**
- Do you drink alcohol? **YES or NO**
- Do you use illegal drugs? **YES or NO**
- Do you currently drive? **YES or NO**

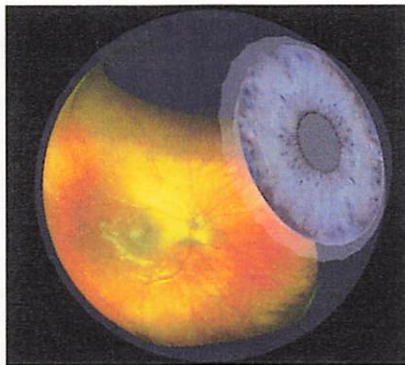
The above information is accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# IN FOCUS

EYE CARE CENTER

KARL M. LARSEN O.D.  
NEIL K. DICKERSON O.D.



We are proud to introduce the latest in retinal imaging, the Optomap. It is painless, quick and the doctor's preferred method at looking at the health of your eye. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as **hypertension, diabetes, high cholesterol, and thyroid problems**. Through this digital imaging of the retina we can observe early changes in the eye relating to **glaucoma, cataracts, and macular degeneration**. This technology is now our new standard of care.

***\*\*Due to the fact this is newer technology, most insurance companies are not yet covering this procedure. Should your vision insurance not cover Optomap images there will be a nominal fee of \$30.00 for this procedure. \*\****

Please check one of the following: ☐ Yes, I would like this new procedure.

☐ I want to discuss with the doctor. ☐ No, I would not like this new procedure.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

We are happy to email you the images taken today, please let us know where to email them:

\_\_\_\_\_