# 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/LATINO ☐ NOT HISPANIC/LATINO ☐ DECLINE TO ANSWER

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

**SPECIAL NEEDS:** ☐ HEARING IMPAIRED ☐ TRANSLATOR ☐ WHEELCHAIR ☐ OTHER_____

**RACE*:** ☐ AMERICAN INDIAN or ALASKA NATIVE ☐ ASIAN ☐ BLACK or AFRICAN AMERICAN ☐ WHITE
☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ UNKNOWN or OTHER ☐ DECLINE TO ANSWER

**LANGUAGE:** ☐ ENGLISH ☐ SPANISH ☐ PORTUGUESE ☐ POLISH ☐ FRENCH ☐ GERMAN ☐ ITALIAN
☐ OTHER LANGUAGE_____ ☐ DECLINE TO ANSWER

**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**?_____

## RETINAL IMAGING

Southern Colorado Eye Care Associates recommends Retinal Imaging for all of our patients every year. The Imaging 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 **$45.00** per adult and **$25.00** per patient under the age of 18. Military and family discounts available.

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

### EYEGLASSES AND CONTACT LENSES

-When re-using your own frame, Southern Colorado Eye Care Associates' staff is not responsible for any damage or breakage during the process of putting new lenses into your frame._____(initial)

- Contact lens evaluation includes fitting, refitting, and/or insertion & removal training. Evaluation fee depends on complexity of contacts and starts at $30. _____(initial)

### HIPAA 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 may 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 Associates 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. **Accounts in default or sent to collections will be charged an additional $50.**

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

HIPAA/INSURANCE ACKNOWLEDGMENT

**The choices of Race and Ethnicity are consistent with choices used in US Census surveys.*

**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**

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

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

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

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

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

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

**TOBACCO USE:** □ SOME DAY SMOKER □ EVERYDAY SMOKER □ FORMER SMOKER □ NEVER SMOKER