



**Personal Information**

Legal Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_  
Occupation \_\_\_\_\_ Employed at: \_\_\_\_\_ Student \_\_\_\_ (yes) \_\_\_\_ (no)  
Activities/Hobbies/Sports \_\_\_\_\_  
Address \_\_\_\_\_ Soc. Sec. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Day Time Phone \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
How did you find our office? \_\_\_\_\_ Internet Search \_\_\_\_\_ Insurance \_\_\_\_\_ Drive By  
Dr. Referral: \_\_\_\_\_ Friend: \_\_\_\_\_ Other: \_\_\_\_\_

**Responsible Party - After Insurance**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

**Vision Insurance Name** \_\_\_\_\_ Primary's Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Card Holders Name \_\_\_\_\_ Primary's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Medical Insurance Name** \_\_\_\_\_ Primary's Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Card Holders Name \_\_\_\_\_ Primary's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Member's ID # \_\_\_\_\_ Group # \_\_\_\_\_ **& COPY OF CURRENT MEDICAL CARD**

**Digital Retinal Imaging**

Digital Retinal Imaging is a new technology that Dr. Stites uses to take a digital scan of the inside of the eye. This procedure allows early detection of many eye diseases, including Glaucoma, Macular Degeneration, Diabetic/Hypertensive Retinopathy, Juvenile Developmental problems and numerous others. It can replace the need for Pupil Dilation in many instances. The fee for this service is \$35.00 and is not covered by insurance. Would you like to take advantage of digital retinal imaging? Yes \_\_\_\_\_ No \_\_\_\_\_

*Thank you for choosing us to care for your vision and ocular health!*

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Are you planning on getting new glasses or contact lenses today? \_\_\_\_\_

**Medical History**

Name of Medical Dr: \_\_\_\_\_ City/street \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medical Allergies: \_\_\_\_\_ Are you currently pregnant or nursing?  no  yes

Have you had any eye injuries or surgeries? \_\_\_\_\_

**Family History**

Family history of: Glaucoma Y / N who: \_\_\_\_\_  
 Cataracts Y / N who: \_\_\_\_\_  
 Macular degeneration Y / N who: \_\_\_\_\_  
 Medical conditions Y / N who: \_\_\_\_\_  
 Other who: \_\_\_\_\_

**Social History**

Current occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Do you use tobacco products \_\_\_\_\_? Do you use alcohol \_\_\_\_\_?

Have you been infected with:  HIV  Hepatitis  Syphilis  None

**Review of Systems**

Do you have any medical conditions that you are under treatment for?

Medical condition	Yes	No	Explanation of Problem
Vascular (diabetes,HBP,heart,blood)			
Respiratory (asthma, empysema)			
Ears / Nose / Throat			
Gastrointestinal (stomach , intestines)			
Bone / Joint (arthritis)			
Endocrine (diabetes, thyroid)			
Neurology (stroke, migranes, MS)			
Allergic / Immunologic			
Skin (cancer, acne)			
Eyes (vision loss, pain, redness, etc)			
Genitourinary (kidney, bladder)			

\_\_\_\_\_  
Patient or parent/guardian signature Date

## Authorization and Release for Billing and Assignment of Benefits

I understand and agree that I am responsible for any fees for services rendered to myself and/or for my dependents. I hereby authorize the physicians of Stites Eye Care to furnish information including diagnosis and the records of any treatment to my insurance carrier concerning all vision and medical conditions. I understand that my insurance carrier may pay less than the actual bill for services. I hereby assign to Stites Eye Care payments made by my insurance carrier until such time as I revoke this in writing.

**Signature of patient/  
or Parent if minor** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Notice of HIPPA Privacy Practices

I have been presented with the Stites Eye Care Notice of Privacy Practices, and have been offered a copy of such to keep with my records.

**Signature of patient /  
or Parent if minor** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Authorization to Discuss My Account

A). It is the policy of Stites Eye Care to communicate with our patients via regular mail, email or by telephone regarding appointments, exam results, eyeglass orders, etc..

B) . \_\_\_\_ I authorize the following to discuss and request disclosure regarding my vision/medical records:

1). His/Her Name \_\_\_\_\_ Relationship to patient

2). His/Her Name \_\_\_\_\_ Relationship to patient

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Medicare Beneficiary- Signature on File *if Applicable*

Name of Beneficiary \_\_\_\_\_ Medicare Number \_\_\_\_\_

I authorize any holder of medical information about me, to release to the Center for Medicare Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_