Personal Information

Legal Name ____ Nickname __________________________

Date of Birth ______/______/______ Minor ______ Single ______ Married ______

Occupation ___________________ Employed at: _____________________ Student ___ (yes) ____ (no)

Activities/Hobbies/Sports ____

Address ____ Soc. Soc. ________________________

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**

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 / Thoat			
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 / ____ **Date** _____/_____/_____
or Parent if minor

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** _____/______/_____

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 <u>allows early detection of many eye diseases</u>, including Glaucoma, Macular Degeneration, Diabetic/Hypertensive Retinopathy, Juvenile Developmental problems and numerous others**.** <u>It can replace the need for Pupil Dilation</u> in many instances. The fee for this service is $45.00 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!