Stites
Eye Care

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**

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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

Stites
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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 HIPAA 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 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 $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!