Eye Etc.

Michael G. Stamboly, O.D.

PATIENT INFORMATION

Thank you for choosing our office for your vision care. If you have any questions or concerns, please ask.

Title:_____ First Name:_____ Middle:_____ Last: Name:_____

Nickname:_____ DOB: ____/____/_____ Sex: ____ Vision Insurance:_____

Address: _____ Insurance ID/SS#_____

City: _____ State: _____ Zip: _____ e-mail:_____

Preferred Contact Phone #: _____ C H W Preferred Contact: Phone E-Mail Text

Referred by: _____ Primary Physician: _____

Last Exam:_____ Occupation:_____ Hobbies:_____

Reason(s) for Today's Visit:_____

HEALTH HISTORY

Please check appropriate boxes for yourself or immediate family members:

Self	Self	Family	Self	Self
☐ Hypertension	☐	☐ Diabetes	☐ Environ. Allergies	☐ Refractive Surgery
☐ High Cholesterol	☐	☐ Cataracts	☐ Medicine Allergies	☐ Eye Surgery
☐ Heart Disease	☐	☐ Glaucoma	☐ Asthma	☐ Eye Injury
☐ Stroke	☐	☐ Retinal Disease	☐ Sinus Trouble	☐ Eye Infection
☐ Thyroid Dysfunction	☐	☐ Macular Degeneration	☐ Dry Eyes	
☐ Unusual Headaches	☐	☐ Amblyopia (lazy eye)	☐ Color Vision Problems	
☐ HIV	☐	☐ Strabismus (eye turn)	☐ Other_____	

Please List Current Medications:

_____

CONTACT LENSES

☐ Wear contact lenses? Type_____ Solution_____ ☐ Not wearing lenses now, but have tried.

☐ Daily Wear (removed nightly) Hours/Day____ ☐ Continuous Wear (slept in) ☐Interested in trying contact lenses.

We may need to instill eye drops to dilate the pupils in order to more thoroughly examine the eyes. This allows a more comprehensive evaluation of both ocular and systemic health. You will experience blurred near vision, light sensitivity and a mild decrease in distance vision for about four to six hours after dilation.

☐ I Accept Dilation ☐ I Decline Dilation ☐ I Prefer to Reschedule Dilation

Signature_____ Date_____

OVER

PATIENT AKNOWLEDGEMENT FORM

I understand Eye Etc.'s legal obligation to keep identifiable health information private and confidential. I understand that Eye Etc. may use and disclose the patient's personal health information for treatment, payment and health care operations.

Eye Etc. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

Within this "Notice of Privacy Practices" is contained a complete description of my privacy and confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law and requesting that communications to me regarding my care be by specified methods.

Eye Etc. has established procedures which helps them meet their obligation to patients. These procedures may include other signature requirements and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist Eye Etc. by following these procedures if I choose to exercise my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of Eye Etc.'s "Notice of Privacy Practices" and I am consenting to Eye Etc. to use and disclose my protected health information to carry out treatment, payment and health care operations.

I may revoke this authorization in writing except to the extent that the practice has already made disclosures in reliance upon my prior authorization. A photocopy of this shall be considered as effective and valid as the original.

Signature of Patient or Responsible Party: _____ Date: _____

It is the patient's responsibility to know who is the Provider of their Vision Care Benefits.
Once authorized, we can explain your benefits and costs to you.
Your Insurance/Benefits card or ID must be given to us BEFORE your time of service.
Patients are responsible for fees not covered by their insurance.
If no Benefits or Insurance are made known to us before services are provided, patients are responsible for all fees on services and materials. No Refunds.

Your appointment time is reserved exclusively for you. If you fail to show for your appointment without canceling 24 hours in advance, you will be subject to a no-show fee.

Please sign that you have read and agree to this office policy.

Patient or Responsible Party:_____Date:_____