Dalton Eye Care Patient Information

Thank you for selecting Dalton Eye Care for you eye care. Should you have any questions or concerns we will be pleased to assist you.

Mr. ( ) Ms. ( )_____Title or suffix (if applicable) _____

last first middle initial

Date of birth_____Age:_____Social Security Number _____-____-_____new patient Y or N_____

Address_____ Apt:_____City:_____State_____ Zip _____

phone _____Work phone:_____Cell/page _____

Employer_____ Occupation _____

Business Address _____ City/State/zip _____

married____ single____ other____

Name of spouse/parent_____Employer _____

If student what school/college?_____ City/State _____

How did you hear about Dalton Eye Care?_____

Responsible Party If the patient above is responsible check here _____and skip section below.

Name of person responsible_____**Phone** _____

Address_____City/State/Zip _____

Employer _____Work Phone _____

Insurance Information

Name of insurance plan_____

Name of insured_____ Relationship to insured_____

Date of birth_____Social security number _____-____-_____

Name of employer_____work phone_____

Address of employer_____City/State/Zip _____

Insurance Company _____ Group #_____ ID# _____

Insurance Company address_____ City/State/Zip_____

What is your deductible?_____How much have you used?_____Max. annual benefit?_____

Do you have additional insurance?_____No _____ Yes If yes, please complete the following.

Name of insurance plan_____

Name of insured _____ Relationship to insured_____

Date of birth _____Social security number _____-____-_____

Name of employer _____work phone_____

Address of employer _____City/State/Zip _____

Insurance Company_____Group #_____ ID# _____

Insurance Company address_____ City/State/Zip_____

Authorization

I certify that I have read all to the above information and it is correct to the best of my knowledge, as well as any medical information on the following forms. I understand that providing incorrect information can be dangerous to my health. I authorize Dalton Eye Care to release any information including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dalton Eye Care, insurance benefits otherwise payable to me. I understand that my eye care insurance may pay less than the actual bill. I agree to be responsible for payment of all services rendered in my behalf or my dependents. I am aware that if my account is turned over to a collection agency, a fee of $30 will be added to any remaining balance. I am also aware that polycarbonate lenses are the safest material on the market. Impact resistant lenses, regardless of material, are not shatterproof or break-proof, and they will not provide an unbreakable shield against eye injury. Please be advised a copy of our Privacy Practices should be provided with your information package. I have read the privacy practices and am aware of my rights and privledges.

_____

Signature of patient or guardian if minor Date

Dalton Eye Care: Sullivan, MO 63080; 573-468-2020

Consent to use or disclose health information for treatment, payment and health care operations.

Patient name_____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ If minor child write “minor” and sign below

Patient Dated

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____

Relationship to Patient Print Name

_____

Source of Authority

Dalton Eye Care: Sullivan, MO 63080 573-468-2020

Dear Patient,

Your medical history can have an important impact on your vision. Please answer all questions as completely as possible, so we can be parnters in you health. Please keep in mind that medical records are confidential and will be secured. Please see privacy disclosure.

Thank you

Name_____ Age:_____ DOB___/___/___ Phone:_____

Address_____ City:_____ State____ Zip_____

Do you have any medical conditions? Please list all below.

_____

_____Do you take any prescription or over the counter medications? Please list all below.

_____

_____Do you smoke? Y or N? How many packs/day?_____ How many yrs____?

Do you take any medications or drugs (legal or illegal) not prescibed by your physician? Please list any not listed above:_____

Do you drink alcohol? Y or N How many drinks a week?_____

Are you Allergic to any medications or any other substances? Please list below.

_____

_____Have you had any injuries or surgeries to your eyes? Y or N

Explain:_____

Do you wear glasses? Y or N How old are they?_____yrs

Do you wear for reading distance or both? Please circle.

Do you wear contact lenses? Y or N How old are they? _____ What type?_____

Please check any of the following that you are having difficulty with your vision or eyes.

__Loss of vision	__Loss of side vision	__Double vision	__Blurred vision
__Itching	__Excessive tearing	__Redness	__Burning
__Dryness	__Pain	__Gritty eyes	__foreign body
__eye infection	__Flashes	__Floaters	__Mucous
__Glare	__Light sensitivity		

Please indicate below if you or your immediate family members (parents, grandparents, siblings or children) have any of these conditions.

Eye	YOU	FAMILY	describe and identify relationship
Retinal detachment	[ ]	[ ]	_____
Cataracts	[ ]	[ ]	_____
Crossed Eyes	[ ]	[ ]	_____
Lazy Eyes	[ ]	[ ]	_____
Amblyopia	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Color blindness	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____

	You	Family	
Cardiovascular			
Heart disease	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	_____
Vascular disease	[ ]	[ ]	_____
Stroke	[ ]	[ ]	_____
Respiratory			
Emphysema	[ ]	[ ]	_____
Asthma	[ ]	[ ]	_____
Integumentary			
Skin disorder	[ ]	[ ]	_____
Eczema	[ ]	[ ]	_____
Urinary			
kidney disease	[ ]	[ ]	_____
urinary tract infection	[ ]	[ ]	_____
Endocrine			
Diabetes	[ ]	[ ]	_____
Thyroid	[ ]	[ ]	_____
Neurological			
Headaches	[ ]	[ ]	_____
Migraines	[ ]	[ ]	_____
Seizures	[ ]	[ ]	_____
Dizziness	[ ]	[ ]	_____
Hearing loss	[ ]	[ ]	_____
Blood & Lymph			
Bleeding disorder	[ ]	[ ]	_____
Anemia	[ ]	[ ]	_____
Immune / Immune deficency	[ ]	[ ]	_____
Psychiatric / Depression	[ ]	[ ]	_____
Anxiety	[ ]	[ ]	_____
Gastrointestinal/ stomach	[ ]	[ ]	_____
Reproductive (you only)			
Pregnant or nursing	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Bone/Muscle:			
Arthritis	[ ]	[ ]	_____
Muscle weakness	[ ]	[ ]	_____

Thank you for answering these questions.

Please sign and date form _____ date __/__/__

Doctor initials and date _____ date __/__/__