Centennial Family Eye Care

Patient History Form

PERSONAL INFORMATION

Name:_____ Date:_____
Address:_____ City:_____ State:____ Zip:_____
Birth Date:_____ Age:_____ SS#:_____ Occupation:_____
Home#:_____ Cell#:_____ Work#:_____ Last Eye Exam:_____
Email:_____ Whom may we thank for referring you?_____
☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Minor Sex: ☐ Male ☐ Female

INSURANCE INFORMATION

Medical Insurance #1:_____ Medical Insurance #2 :_____
Primary Insured Name:_____ DOB:_____ SS#_____
Employer:_____ Group #_____ ID#_____
Secondary Insured Name:_____ DOB:_____ SS#_____
Employer:_____ Group #_____ ID#_____

GENERAL INFORMATION

Do you currently wear glasses? ☐ **Yes** ☐ **No** How old are they?_____
Do you wear contact lenses? ☐ **Yes** ☐ **No** Type:_____
Are you interested in wearing contact lenses? ☐ **Yes** ☐ **No**
Do you have visual difficulty when driving? ☐ **Yes** ☐ **No** If yes, explain:_____
Have you ever been exposed to an STD/STI? ☐ **Yes** ☐ **No** Do you: ☐ Smoke ☐ Drink ☐ Use Drugs

MEDICATIONS

Medications [ALL MEDICATIONS, including herbal and over-the-counter] : ☐ **None** _____
_____
_____
Allergies to Medications: ☐ **None** _____
_____

FAMILY MEDICAL HISTORY

Please note any family history of the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____

MEDICAL HISTORY

	YES	NO
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY [skin]	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye	☐	☐
Styles or Chalazia	☐	☐
Flashes/Floaters	☐	☐
Tired Eyes	☐	☐
Glaucoma	☐	☐
GENITOURINARY		
Kidney/Bladder/Genitalia	☐	☐

	YES	NO
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR	☐	☐
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Stomach/Intestines	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐
ENDOCRINE		
Thyroid	☐	☐
PSYCHIATRIC		
Depression/Anxiety	☐	☐

If "yes" to any of the above, or if a condition is not listed, please explain below:_____

Date	Changes Noted [since last visit]	Doctor Reviewed

Medical Records Release
Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____
Patient SSN:_____
Patient DOB:___/___/___

I,_____, authorize the custodian of records of, **CENTENNIAL FAMILY EYECARE**, to disclose/release the following information* (check all applicable)

☐ All records
☐ Billing records
☐ Glasses/Contacts RX
☐ Picking up of glasses/contacts

****NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information****

Please disclose/release listed above to (use additional if necessary):

Name:_____
Name:_____
Name:_____

This authorization shall expire no later than: one year after date of signature

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient(or patient's personal representative)

_____
Printed name of patient/patient representative

_____
Date

_____
Representative's authority to sign for patient
(i.e parent, guardian, power of attorney for healthcare, executor)

Centennial Family Eye Care

Text Messaging

Centennial Family Eye Care offers a text messaging service for conformation of upcoming appointments. We would like to send a reminder text message the day before your appointment or if you have missed an appointment. This process allows you to confirm your appointment without receiving a phone call. With your permission we would like to add you to our approved text messaging list. Thank you

Please Check One:

☐ I want to receive text messages

☐ I do not want to receive text messages

Patient Name:_____

Cell Phone Number:_____

Signature:_____Date:_____

(If patient is under 18, parent/guardian must sign)

Centennial Family Eye Care

Acknowledgement Notice of Privacy Practices

Signing in this section signifies that you have received/viewed a copy of our Notice of Privacy Practices.

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 these services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Record Retention Policy

We are informing you that our office will keep your records for 5 years from the date of this examination. If signing for a minor, please be aware that our office will only keep your child's records for 5 years from the date of this examination.

Patient Signature:_____ Date:_____

If patient is a minor (under 18 years old), parent/guardian must sign this.

Signature on File

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Centennial Family Eye Care, and/or any of their associates to release and/or request these records. If applicable, I request that payment of authorized Medicare or other insurance be made either to me or on my behalf to Centennial Family Eye Care, for any services rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.

I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is the policy of this office to require:

1) Payment in full or at least one-half before the order can be placed.

2) The balance of the fee must be paid at the time the order is dispensed.

3) All orders are final when placed.

Patient Signature:_____ Date:_____

If patient is a minor (under 18 years old), parent/guardian must sign this.

Centennial Family Eye Care

Digital Retinal Photography

The D.R.P. takes a digital view of the back of your eye and puts it into the format of a picture, which is saved onto a computer. This scan can be viewed immediately and examined by the Doctor while you follow along. The digital view allows the Doctor a much wider field of view than most traditional retinal exams provide of your retina. Also, because the photo is saved onto a computer, it serves as documentation of the current condition of your eyes, which can aid in the tracking of any changes over the years should anything occur in the future. The Doctor strongly recommends that the patients of our office have this procedure done to allow him/her to utilize all tools available to assess the health of the eyes, and especially if any of the following apply:

- ☐ **DIABETES**
- ☐ **CATARACTS**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **FREQUENT OR SEVERE HEADACHES**
- ☐ **HIGH NEARSIGHTEDNESS**
- ☐ **FLASHES OF LIGHTS/FLOATING DOTS**
- ☐ **PERSONAL OR FAMILY HISTORY OF GLAUCOMA**
- ☐ **OVER THE AGE OF 40**

The entire procedure, in most cases, takes less than 5 minutes to complete. There are no side effects to this procedure like those normally associated with dilation, such as sensitivity to light and/or blurry vision.

The charge for this procedure is $30.00.

If you have any further questions or concerns, the Doctor will be happy to address those with you during your exam.

- ☐ I want to have the DRP done today and am aware of the charge.
- ☐ I do not want to have the DRP done today.
- ☐ I want to schedule the DRP for another day.

Patient Signature:_____ Date:_____

If patient is a minor (under 18 years old), parent/guardian must sign this.

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Dilation of the Eyes

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near, and less commonly at distance. You may be sensitive to light. You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we can reschedule the dilation portion of your exam. A routine dilation of the eyes is recommended at least once every 2 years. There are certain systemic and ocular conditions that require your eyes to be dilated every year. Signing in this section signifies that you have been informed of the risks and benefits of dilation.

If you suffer from any of the following conditions you are highly recommended to have your eyes dilated today:

☐ **DIABETES**

☐ **CATARACTS**

☐ **HIGH BLOOD PRESSURE**

☐ **FLASHES OF LIGHTS/FLOATING DOTS**

☐ **PERSONAL OR FAMILY HISTORY OF GLAUCOMA**

If you experience severe headaches, red/painful eyes or nausea after your eyes have been dilated, please return to our office or call immediately. The doctors will be happy to answer any questions you may still have regarding this procedure.

☐ I want to have my eyes dilated today.

☐ I do not want to have my eyes dilated and assume the responsibility of having an eye exam without dilation.

☐ I want to schedule dilation for another day.

Patient Signature:_____ Date:_____

If patient is a minor (under 18 years old), parent/guardian must sign this.