Sullivan | Ostoich
eye center

WELCOME TO OUR OFFICE

Personal Information

Patient name_____ Email_____

Address_____ City_____ State_____ Zip_____

Social Security Number_____ Birth Date_____ Hobbies_____

Home Phone Number_____ Cell Phone_____ Work Phone_____

You or your parent's employer_____ Occupation_____

How did you learn of our office?_____

Date of last exam_____ Name of eye doctor_____

Do you currently wear glasses?_____ When do you wear glasses? (Please circle all that apply)
All the time Work Safety Reading/Near work Distance only Computer work other_____
Have you ever worn contacts?_____ Type?_____ Are you interested in contacts?_____
Have you had LASIK surgery?_____ Are you interested in LASIK surgery?_____

Personal Eye Information

Do you have any eye condition or problems? ____ Yes ____ No What kind?_____
Have you had any eye operations? ____Yes ____No Type_____ Date_____
Have you had any eye injuries? ____ Yes ____ No Kind_____ Date_____
Have you been diagnosed with any of the following? (please circle all that apply)
Glaucoma Cataracts Macular Degeneration Retinal Detachment
Additional Information_____

Medical Information

Do you have problems with any of these systems? (please circle if applicable to you)

Gastrointestinal	Nervous	Endocrine (glands)
Ears/Nose/ Throat	Blood/Lymph	Urinary
Cardiovascular	Muscle/ Bones	Allergic/Immunologic
Respiratory	Skin	Headaches
High Blood Pressure	Eyes	Mental

Please Explain_____
Have you been diagnosed with diabetes? Yes No Type_____ Date of diagnosis_____
Allergies to any medications? Yes No Which?_____ Reactions?_____
Other health problems?_____
Current Medications?_____
Have you had any operations?_____ What kind?_____ When?_____
Name of Primary Care Physician_____ Last Physical_____

Family History

High Blood Pressure __ yes __ no Relation_____ Macular Degeneration __yes __ no Relation _____
Diabetes __ yes __ no Relation_____ Retinal Detachment __yes __ no Relation_____

Glaucoma __ yes __ no Relation _____ Cataracts __yes __ no Relation_____

Sullivan-Ostoich Eye Center
Medical Test Authorization

Digital Retinal Imaging is a new technology that allows instant viewing of retinal images by the doctor and patient. This computerized technology helps us by establishing baseline images of the inside of your eyes. We can then compare this image with future images and carefully observe any normal or abnormal vision conditions such as glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions, which can result in permanent vision loss if not caught and treated in a timely manner.

We **strongly** encourage all of our patients to receive these medical tests yearly. It is especially important for patients who have:

Headaches	History of high blood pressure
Spots or Flashes of light	History of diabetes
Circulatory problems	Family history of eye disease
Eye pain	Strong eyeglass prescriptions

Please check the appropriate line below and sign at the bottom.

_____ Yes, I do wish to have the digital retinal images taken of the back of my eyes today. I understand there is a $35.00 charge, which is not covered by insurance.

_____ No, I DO NOT wish to have the above medical tests today. I understand the doctors' recommendations but decline at this time.

Patient's Signature:_____ Date:_____

For Dr. Sullivan & Dr. Mata Patients:

I understand that my exam today will be submitted to my Medical Insurance, NOT any Vision Insurance Plans. _____ (Initials)

Please provide us with information you may have on your **primary care physician** so we may send them any necessary medical reports and updates.

Doctors name: _____ Phone number/ town_____

Acknowledgement of receipt of Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

I, _____, Have received the NOTICE OF PRIVACY PRACTICES from Sullivan- Ostoich Eye Center, LTD.

I do **OBJECT** to :

Phone calls to my home_____, place of employment _____, cell _____
Messages left on my answering machine/ voicemail_____
Messages left with someone in my household _____

Please note: All mail will be sent to your home address and no information will be faxed or emailed to you or others without your written permission.

_____ _____
Signature of Patient or Legal Guardian Date

Authorization_____

I authorize this office to release any information, including the diagnosis and the records of any treatment examination rendered to me or my child 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 the eye doctor insurance benefits otherwise payable to me. I understand that my insurance company may pay less than the actual bill for the services and agree to be responsible for payment of all service rendered on my behalf of my dependents. I also authorize this office to send my pertinent vision information (i.e. recalls, etc.) to the above address and email address.

X_____ Date_____