My Family Eyecare
820 Stateline Road
Colcord, OK 74338
918.422.5811

Welcome to our office!

Date _____
Last Name _____ First Name _____ MI _____
Mailing Address _____
City _____ State _____ Zip _____
Cell Phone _____Work Phone _____
Home Phone _____ Where do you work? _____
SSN _____ DOB _____ Sex _____
Email Address _____
How do you prefer us to contact you? ____Text ____ Cell ____ Home ____ Email
Emergency Contact _____ Phone _____
Marital Status _____ Spouse's Name _____
Race (optional) _____
Primary Language (optional) _____
Special Needs (optional) _____

Responsible Party _____ DOB _____
Relationship to Patient _____ Phone _____
Responsible Party's Workplace _____ Phone _____

Insurance Information:
Vision Plan _____
Member or Subscriber _____ SSN _____
DOB _____
Primary Medical Insurance _____
Member or Subscriber _____ SSN _____
DOB _____
Secondary Medical Insurance _____ SSN _____
DOB _____

How will you be paying for your services today? ____ Cash ____ Check ____ Credit/Debit
Do you participate in a Health Savings Account or Flex Spending Account? ____ Yes ____ No

When was your last exam? _____
Where was your last exam? _____

Should you need refractive correction, are you wanting glasses, contacts or both? _____
If you are an experienced contact lens wearer, what brand do you wear? _____
What solution do you use? _____

What problems have you been having? Please check all that apply.

____ Blurry Vision ____ Eye Irritation ____ Sunlight Sensitivity
____ Eye Turn/Crossed Eye ____ Flashes of Light ____ Double Vision
____ Dryness ____ Floaters or Spots ____ Headaches
____ Trouble Seeing at Night
____ Other, Please Explain _____

We also offer our **I Wellness Screening** that reveals early indications of retinal or nerve disease. This screening is a non-invasive "picture" of the interior portion of your eye referred to as your retina. Dr. Vaughan recommends that every patient consider this screening as it helps to detect any vision threatening issues or any systemic disease. As a new patient, Dr. Vaughan will also use this screening as a baseline of retinal health. These images will help her determine what is normal for you as an individual. From these images, Dr. Vaughan will be able to detect any small changes that may happen over time. This information can be valuable in seeing changes over time.

If you want to have this important screening performed today, please check the box below and we will see to it that our technician discusses it with you. We are offering this important test for only $28 as it is truly a helpful tool. It is, however, not covered by most insurances. Should you decide to have this test performed, the charge will be your responsibility.

_____ Yes, I want to have the **I Wellness Screening**

Medical History:

Please tell us about the history of eye disease in your family _____
_____
_____

Please tell us about the family history of any other diseases in your family _____
_____
_____
_____

Name of your Physician _____
Where is your Physician Located _____
Date of Last Physical Exam _____

Current Medications (including vitamins, eye drops or birth control) _____
_____
_____
_____

Do you have any allergies to any medications? ____ Yes ____ No
If yes, what medications? _____

Please list any diseases, disorders, surgeries or physical problems that are an issue for you now or in the past _____
_____
_____
_____

Do you smoke? ____ Yes ____ No
Have you ever smoked? ____ Yes ____ No
Do you use other tobacco products? ____ Yes ____ No
Do you vape? ____ Yes ____ No
Do you use alcohol? ____ Yes ____ No

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV or Syphilis?
____ Yes ____ No If yes, which one(s) _____

Whom may we thank for referring you to our office today?
_____

If there was not a referral, how did you hear about us? _____

Signature on File

We are required by law to have your signature on file stating that you received a copy of the Privacy Notice. (We will provide a copy at your request.)

I, _____ acknowledge that I have been offered a copy of the Privacy Notice for the office of My Family Eyecare.

I also give my permission for the office to correspond with me via email.

Dilation is a significant part of the eye health examination. It should be performed at least every two years. I give my permission to have Dr. Vaughan dilate my eyes today.

_____ Yes _____ No

I certify that the information given by me in applying for payment by my insurance company is correct.

*I authorize use of this form on all my claim submissions
*I authorize release of information to all of my insurances companies as needed to process claims for payment.
*I authorize my doctor to act as my agent in helping obtain payment from my insurance companies.
*I authorize payment directly to my doctor.
*I permit a copy of this authorization to be used in place of the original.
*I authorize the release of personal health information to any other physicians or personnel who who may be utilized.

IMPORTANT: Payment is expected today for all copays, deductibles and non-covered services. As a courtesy to you we will bill your insurance for you for those services they may cover. We will make a good faith effort to collect all payments from your insurance companies for the services we provide to you. However, if payment is not received from your insurance companies within 60 days of filing, the balance will become your responsibility.

I have read all of the above and I give my consent and permission for each as it is written.

Signature _____ Date _____