Fulton EyeCare Center
Robert Fulton, O.D.

Last Name: _____

First Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Referred By: _____

Sex: M F Date of Birth: _____

Social Security Number: _____ Medical Insurance: _____

Marital Status: _____ Vision Insurance: _____

Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language: _____

☐ I AGREE TO have my retinal health evaluated

☐ I DO NOT wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

with the EyeScreen Exam.

Race: Native American/Native Alaskan
Asian
Black/Africian American
Hispanic
Native Hawaiian/Other Pacific Island
White

Ethnicity:
Hispanic/Latino
Native Hawaiian/Other Pacific Island
Not Hispanic/Latino

Communication Preferred: Email Telephone Postal

Last Eye Exam: _____ Doctor: _____

EyeScreen Photographic Examination

We at Fulton EyeCare Center are pleased to provide our patients with an advanced digital retinal exam called EyeScreen. EyeScreen is a high-resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the EyeScreen exam to document a baseline image for our charts, screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than a slit lamp or ophthalmoscope.

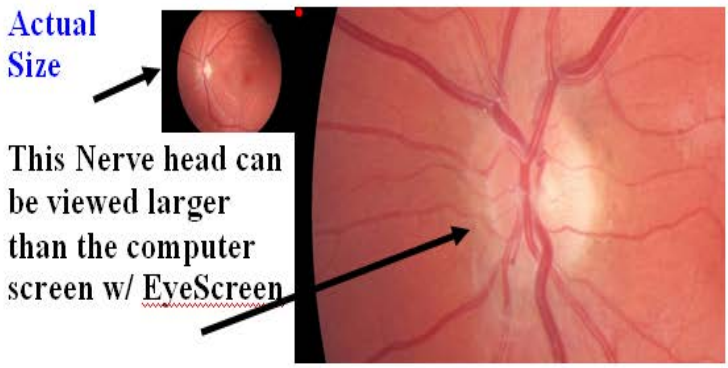
We are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, many symptoms of systemic diseases such as diabetes and the effects of high blood pressure can be detected with the EyeScreen Examination.

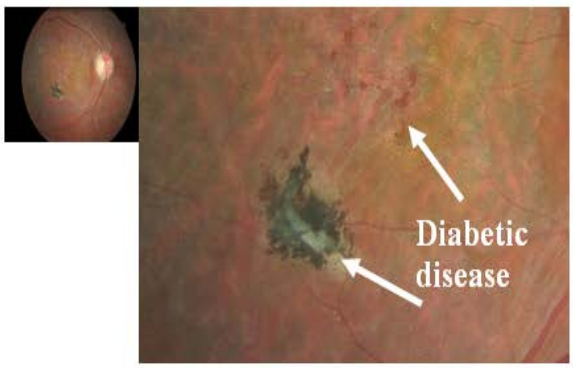
You can expect from this exam:

- An annual eye wellness EyeScreen photograph
- An in-depth view of the retinal surface (where eye diseases first manifest)
- The ability to review the images with you (we will show you your retina)
- A permanent record for your medical file, for serial analysis, comparisons, and diagnosis
- To be fast, easy and comfortable
- Usually no dilation drops for the test (we will inform you if they are required)

Since insurance will only pay for retinal photos after eye disease is discovered the EyeScreen Examination is an out of pocket expense.

Dr. Fulton recommends this procedure for all of his patients and will perform the EyeScreen Exam at an additional cost of $27.00 to the basic eye exam you are receiving today. Please select one of the following boxes on the Health History page.





PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	**Yourself** Yes	No
Cataract		
Eye Turn		
Glaucoma		
Macular Degeneration		
Retinal Detachment		

	Yes	No
Women- Are you pregnant?		
Are you breast feeding?		

	Family Member Yes	No	**Relationship (Blood Relatives Only)**
Blindness			_____
Eye Turn			_____
Glaucoma			_____
Macular Degeneration			_____
Retinal Detachment			_____

Other: _____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic	**Ear, Nose and Throat**	**Gastrointestinal**	**Skin/Integumentary**	**Psychiatric**
None	None	None	None	None
Lupus (SLE)	Sinusitis	Crohn's Disease	Eczema	Depression
Rheumatoid Arthritis	Upper Respiratory	Colitis	Rosacea	Bi-Polar
Environmental Allergies	Tract Infection	Acid Reflux/Ulcer	Psoriasis	Schizophrenia
Seasonal Allergies	Other	Other	Other	Other
Other (i.e., Latex)				

Cardiovascular	**Endocrine/Glands**	**Respiratory**	**Muscle/Skeletal**	**Genital/Urinary**
None	None	None	None	None
High Blood Pressure	Diabetes	Asthma	Arthritis	Urinary Tract Infection
Heart Disease	Hormone Dysfunction	Bronchitis	Fibromyalgia	HIV Positive
Stroke	Thyroid Dysfunction	Emphysema	Ankylosing Spondylitis	Herpes/Chlamydia
Vascular Disease	Other	Other	Other	Other
High Blood Cholesterol				

Hematologic/Lymphatic	**Neurological**	**General Health**	**Social**
None	None	None	Tobacco Use:
Anemia	Multiple Sclerosis	Weight loss/gain	Current Smoker Former Smoker
Leukemia	Epilepsy	Fever	Non-Prescription Drugs_____
Bleeding Disorder	Tremors	Fatigue	Alcohol Consumption_____
Other	Other	Trauma	Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): _____ Date:_____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign this form):_____

Relationship of Patient Representative to Patient: _____

Notice of Privacy Practices

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

Dr. Robert Fulton
402 W Chickasha Ave # 100, Chickasha, OK 73018
(405)224-3937 Fax (405)224-4375

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 Form. As described in our Notice of Private Practices, the use and disclosure of your health information for treatment purposes not only includes care and service 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 (1) our submission of your health information to a billing agent or vendor for processing claims review, determination of benefits and payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) 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 our office.

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 the consent. 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 obliged 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 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.