PATIENT INFORMATION

Date ______________ Referred By ______________ MD/Optometrist

Name (Last) ______________ (First) ______________ (MI) ______________

Address ______________

City ______________ State ______ Zip ______________ Phone (H) ______________

Employer ______________ Occupation ______________ Phone (C) ______________

SS# ______________ Spouse's Name ______________ Family Physician ______________

Sex: M F Birth date ______________ Age _____ E-mail address: ______________

How did you hear about our office?

Physician ___ Family/Friend ___ Hospital ___ Yellow pages ___ Internet ___ Insurance plan ___ Other _______

Emergency contact Name: ______________ Phone Number: ( ) ______________

Do you want ***appointment reminders*** by: Phone _________ E-mail _______ Text _____ **(please check one)**

Insurance holder's information (Parent/Guardian/Guarantor Information)

Name ______________ SS# ______________ Birth date ______________

Address (if different) ______________

Phone (if different) ______________

Employer ______________ Occupation ______________

Work Address ______________ Work Phone ______________

Please bring a copy of your MEDICAL insurance card and vision plan information. We are a medical practice and we do need this information.

Agreement to Pay

I request that payment of authorized insurance and/or Medicare benefits be made either to me or on my behalf to Barbara Schroeder, MD, Natalka Fedoriw, MD, Susan L. Eggebrecht, OD, Eric. P. Purdy, MD, Zachary D. Roth, OD, or Anne S. Krafsig, MD. I further request that any supplemental insurance benefits be filed on my behalf be paid as stated above. I authorize any holder of medical information about me to release to my insurance and/or the Health Care Financing Administration (HCFA) and its agent any information needed to determine these benefits or the benefits payable for related services. I (we) agree to pay my account, as services are rendered, i.e. co-payment, deductible, or percentage not covered by my insurance company. I (we) understand that responsibility for payment is mine (ours) due and payable at the time of service unless financial arrangements have been made. I (we) further understand that if my account is sent to collections/attorney I (we) promise to pay 18% annual interest and any court costs, and reasonable attorney's fees needed in order to collect the balance owed.

Consent for Care and Treatment

I, the undersigned, do herby agree and give my consent for Vision Care Ophthalmology (VCO) to furnish medical care, procedures and/or treatment to me. This treatment or care is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition.

Signature of patient/personal representative: ______________________________ Date: ________________

Photography Consent

I give VCO permission to photograph myself/my child for security purposes. I understand the picture will be retained in my/their medical record and will be used for identification purposes only.

Signature of patient/personal representative: ______________________________ Date: ________________

RELEASE OF INFORMATION ___ Accept

I have been offered a copy of the HIPAA notice of Privacy Practices to read _______(Initial) ___ Decline

I authorize the following person(s) to discuss my care and treatment with VCO physicians or personnel:

Name: ___________________________________ Relationship to Patient: ____________________________

Name: ___________________________________ Relationship to Patient: ____________________________

Or – I DO NOT want my care or treatment discussed with anyone but me _____ (Initial)

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis etc.)
   Yes ____ No ____ If YES, please explain: ____
2. Have you ever had any eye disease? (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)
   Yes ____ No ____ If YES, please explain: ____
3. Have you ever had any surgery?
   Yes ____ No ____ If YES, please provide date and reason: __________________________________
   ____
4. Have you ever been hospitalized?
   Yes ____ No ____ If YES, please provide date and reason: __________________________________
   ____
5. Do you have any drug or food allergies?
   Yes ____ No ____ If YES, please list: ____
   ____
6. Do you wear glasses? Yes No
7. Do you wear contact lenses? Yes No
8. Do you have difficulty seeing when driving? Yes No
9. Do you have a problem with night vision? Yes No
10. When was your last eye exam? __________________ By whom? _________________________________

REVIEW OF SYSTEMS

Do you currently have any of the following problems?	**Yes**	**No**	**If YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	____	____	________________________
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	____	____	________________________
Heart problems (e.g. chest pain, irregular heart beat)	____	____	________________________
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	____	____	________________________
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	____	____	________________________
Urinary problems (e.g. pain or discomfort, blood in urine)	____	____	________________________
Skin problems (e.g. rashes, excessive dryness)	____	____	________________________
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	____	____	________________________
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	____	____	________________________
Psychiatric problems (e.g. depression, anxiety)	____	____	________________________

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

Yes ____ No ____ **If YES, please list family member(s)** ______________________________________

____

Do you smoke? If yes, how much? ____

Do you drink alcohol? If yes, how much? ____

Pt Name: ___________________________ DOB: ___________________

Date	Medication	Dose	Frequency	Method	Reason	Any changes?