Welcome To HAWK EYE CENTER

Patient Information

Name _____ Sex: □ M □ F Birthdate _____
First Middle Initial Last

Parent/Guardian name (if under 18):_____ Patient's SSN _____

Address _____ Occupation/Grade _____

_____ Email:_____
City State Zip

Home Phone_____ Cell Phone _____ Work Phone _____

Referred by: □ Doctor □ Insurance □ Newspaper □ Coupon □ Walk-in □ Family/Friend Who may we thank for the referral? _____

Patient's Eye History

Date of last eye exam: _____ Name of last eye doctor:_____ Do you wear glasses? □ Yes □ No

When do you wear your glasses? □ All day □ As Needed □ Reading □ Driving/TV Do you wear Contact Lens? □ Yes □ No

Brand of Contact lens:_____ Average contact lens wear time per day: _____ Hrs/Day Contact Lens Solution:_____

Please check any of the following eye conditions that apply to you:

□ Blurred Distance Vision □ Blurred Night Vision □ Eye surgeries □ Flashes of lights □ Headaches/Eye strain □ Floaters or Spots □ Burning Eyes

□ Blurred Near Vision □ Eye Pain □ Eye injuries □ Itchy Eyes □ Dry eyes □ Double Vision □ Red Irritated Eyes □ Watery Eyes

Others:_____

Medical Health History: (Please check any of the following conditions that apply)

	Yourself	Family Member	Relationship to you
Glaucoma	□ No □ Yes	□ No □ Yes,	_____
Cataracts	□ No □ Yes	□ No □ Yes,	_____
Macular Degeneration	□ No □ Yes	□ No □ Yes,	_____
Retinal Detachment / Disease	□ No □ Yes	□ No □ Yes,	_____
Crossed Eyed	□ No □ Yes	□ No □ Yes,	_____
Blindness	□ No □ Yes	□ No □ Yes,	_____
Diabetes	□ No □ Yes	□ No □ Yes,	_____
High blood pressure	□ No □ Yes	□ No □ Yes,	_____
High cholesterol	□ No □ Yes	□ No □ Yes,	_____
Thyroid Disease	□ No □ Yes	□ No □ Yes,	_____
Heart Disease / Cardiovascular	□ No □ Yes	□ No □ Yes,	_____
Cancer, type: _____	□ No □ Yes	□ No □ Yes,	_____
Arthritis	□ No □ Yes	□ No □ Yes,	_____
Pregnant	□ No □ Yes	How many months?	_____

Do you have any other medical condition? _____

Are you allergic to anything? □ No □ Yes, what?_____

Medications you are currently taking:_____

_____

Social History: **(This information is kept strictly confidential. However, you may discuss this portion directly with the Doctor if you prefer)**

Does your vision limit activities of daily living? (Driving, Reading, Working, etc.) □ Yes □ No

If yes, please describe_____

Do you use tobacco products? □ Yes □ No If yes, how often?_____

Do you drink alcohol? □ Yes □ No If yes, how often?_____

Do you use illegal drugs? □ Yes □ No If yes, what types?_____

Have you ever been exposed to or infected with: □ HIV □ Hepatitis □ Tuberculosis □ Chlamydia □ Gonorrhea

Review of System: **(Do you currently have any problems in one or more of the following areas? If yes, please describe.)**

CONSTITUTIONAL □ No □ Yes _____
(Fever, Weight loss or gain, Fatigue)

EARS, NOSE, MOUTH, THROAT □ No □ Yes _____
(Hearing loss, Ear ache, Nasal congestion, Cough, Nasal drip, Dry mouth, etc)

CARDIOVASCULAR □ No □ Yes _____
(Chest Pain, Hypertension, Heart problems, etc)

RESPIRATORY □ No □ Yes _____
(Asthma, Emphysema, Bronchitis, Wheezing, Shortness of breath, etc)

GENITOURINARY □ No □ Yes _____
(Painful urination, Frequent urination, Impotence, Jaundice, etc)

MUSCULOSKELETAL □ No □ Yes _____
(Arthritis, Joint pain, Muscle pain, Cramps, Stiffness, Swelling, etc.)

GASTROINTESTINAL □ No □ Yes _____
(Nausea, Diarrhea, Constipation, Ulcers, etc)

INTEGUMENATARY / SKIN □ No □ Yes _____
(Warts, Growths, Rashes, Breast lumps, etc)

NEUROLOGICAL □ No □ Yes _____
(Headaches, Paralysis, Numbness, Bell's, MS)

PSYCHIATRIC □ No □ Yes _____
(Depression, Anxiety, Mental Illness)

ENDOCRINE □ No □ Yes _____
(Diabetes, Thyroid, Hunger, Thirst)

HEMATOLOGIC / LYMPHATIC □ No □ Yes _____
(Anemia, Bleeding disorders, Transfusion problems)

ALLERGIC / IMMUNOLOGIC □ No □ Yes _____
(AIDS, HIV, Herpes)

Insurance information

Vision Insurance _____ Medical Insurance _____ Med. Ins. ID #:_____

Insured's Name:_____ Relationship to insured:_____ Med. Ins. Group # _____

Insured's Employer:_____ Insured's Birth date _____ Insured's SSN:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance plan(s) stated above and assign directly to Hawk Eye Center all exam and material insurance benefits, if any, otherwise payable to me for materials provided and services rendered. I understand that any quotes provided by Hawk Eye Center are estimates and may not reflect the exact amount that I will be responsible for. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorized Hawk Eye Center and the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature **Relationship**

Dilation (Pupil Enlargement) and Computerized Screening Tests - Please Read Carefully

VISUAL FIELDS TEST – A highly advanced computerized instrument that provides a more thorough visual field screening. This instrument checks for loss of sight in both the central and peripheral areas. Visual field testing can assist us in early detection of glaucoma, retinal problems, and some neurological diseases such as brain tumors and optic nerve disease. It also enables us to better diagnose causes of headaches. **There is an additional fee of $20.00 for this test. Your insurance does not cover this service.**

- □ Yes, I would like the visual fields test
- □ No, I understand the importance of the Visual Field Testing, but I decline to have it performed at this time.
- □ I would like to discuss this with the Doctor.

OPTOMAP RETINAL SCAN – Optomap is an ultra-widefield scan of your retina (the back of the eye), which will help us document, review, and compare your retina over time. We will use the Optomap scan to document a baseline image for our charts, screen for eye diseases and improve our ability to view your internal retinal health at a high resolution. 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 Optomap Retinal Scan. The test is fast, painless and may not require dilation. **There is an additional fee of $39.00 for this test. Your insurance does not cover this service.**

- □ Yes, I agree to have my retinal health evaluated with the Optomap Retinal Scan.
- □ No, I do not wish to have the Optomap Retinal Scan.
- □ I would like to discuss this with the Doctor.

DILATION allows the doctor to thoroughly examine the inside of the eye for diseases such as cataracts, glaucoma, retinal diseases, ocular tumors, and diabetic retinopathy. This procedure is highly recommended for all patients especially those who have not had their eyes dilated in the past 2 years, patients with high prescription, children under 10, and patients over 40 years old. The side effects, which includes blurred near vision, and sensitivity to light will last about 3-4 hours.

- □ Yes, I would like dilation
- □ No, I do not want dilation and assume the responsibility of having an eye examination without dilation.

We are now making greater use of email and texting to communicate with our patients. All patient information is kept strictly confidential. Your email and cell ph # is **NEVER** shared. **May we communicate with you via email and texting: □ Yes □ No**

Signature/Parent's Signature:_____ Date:_____

HAWK EYE CENTER
10304 Blackhawk Blvd, Ste C
Houston, TX 77089
(713) 987-5555

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Personal and Health Information

2. To whom may the information be released [name(s) or class(es) of recipients]: Hawk Eye Center Doctors; referring doctors; patient's insurance companies

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): To treat and manage eye diseases when needed; to file patient's vision insurance for reimbursements.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. [For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

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ACKNOWLEDGEMENT OF RECEIPT of Notice of Privacy Practices

I acknowledge that I received a copy of Hawk Eye Center's Notice of Privacy Practices and have been offered a copy of such policy to keep for my records.

Signature _____ Date_____