GAILMARD EYE CENTER

General Information

First: ______________________________ Last: ___________________________ Patient DOB: ________________

If child, name of parents: ____

Address: ____ Gender: Male Female

City: ____ State: ______ Zip: __________________

Phone: ___________________________ Email: ____

Text message consent ***Email message consent***

Emergency Contact: ____ Relation: ___________________________

Employer (or School): _____________________________ Occupation (or grade): _____________________________

Medical Insurance: ________________________________ Vision insurance: __________________________________

Insured name: ___________________________________ Insured DOB: ______________________________________

Social Security Number: ________ - ________ - ________ Last Eye Exam: ____________________________________

How did you hear about us?____

Health History

Do you currently wear contact lenses? No Yes: What kind? ______________________________________

Do you wear glasses? No Yes: Age of current glasses? ____

Allergic to any medications? No Yes – List meds: ____

Do you use any medications? No Yes – List meds: ____

Do you use tobacco products? No Yes: Amount: ________________ Quit _______________ years ago

Are you being treated or followed for any of the following?

NO GENERAL HEALTH PROBLEMS

Allergies	Endocrine	High Blood Pressure	Fatigue
Arthritis	Depression	High Cholesterol	Fevers
Asthma	Diabetes: AIC _____	Heart Disease	Stroke
Blood/Lymph	Eczema/Psoriasis	Multiple Sclerosis	Rosacea
Cancer	Rheumatoid Arthritis	Crohn's Disease	Cholesterol

Ocular History

Please check if you experience any of these symptoms on a regular basis:

NO PROBLEMS	Distance vision blur	Near vision blur	Floaters
Dry/burning eyes	Foreign body sensation	Excessive watering	Flashes of light
Allergy/Itching	Discomfort with Contacts	Persistent redness	Tired/Strained

Please check if you have been diagnosed/treated for:

Eye Surgery/LASIK	Macular Degeneration	Retinal tear/Detachment	Glaucoma
Cataracts	Eye Turn/Patching	Eye Injury	Dry Eyes

Is there a family history of any of the following?

Macular Degeneration	Father	Mother
Glaucoma	Father	Mother
Keratoconus	Father	Mother

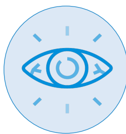
Lifestyle Index

PT INITIALS / ID ______

DATE ______________

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 ○ 2 ○ 3 ● 4 ○ 5 ○

	Symptom	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
	Headaches of any severity each week, usually getting worse later in the day	○	○	○	○	○
	Stiffness / pain in neck / shoulders when you work at a computer or read	○	○	○	○	○
	Discomfort with Computer Use in your eyes (redness, burning) after long hours looking at the screen	○	○	○	○	○
	**Tired Eyes** with increasing feeling of eye fatigue throughout the day	○	○	○	○	○
	Dry Eye Sensation feeling progressively more gritty/sandy while working at computer or reading	○	○	○	○	○
	Light Sensitivity especially with brighter, stronger lights like fluorescents or headlights	○	○	○	○	○
	Dizziness or an experience like motion sickness or vertigo	○	○	○	○	○

FOR OFFICE USE

Neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	

MKT-9072 12312021

Two methods to review the back of the eye: **PLEASE SELECT FROM THE FOLLOWING:**

Eye Health Evaluation

- **Dilation:** Dilation is the accepted standard of care and is **included** as part of your routine vision exam. Dilation involves drops to open your pupil so the doctor to review the back of your eye.
  - **Side Effects:** (Temporary but will last several hours)
    - Blurry near vision for 2-4 hours
    - Light sensitivity for 2-4 hours
    - 30 minutes for the drops to take effect
- **Optomap:** This gives your doctor a wide view of the retina, which is the back of the eye, without dilation. An annual, permanent record of your medical file, used in comparison year to year.
  - **Not covered by Insurance:**
    - **$39.00 out of pocket cost**
- **Decline both Optomap and Dilation:** I have read and understand the above and DECLINE dilation and the Optomap at this time. If I decline dilation and the Optomap, I release Gailmard Eye Center of any liability resulting from failure to detect and refer any internal retinal pathology.

Name of Patient (Please Print): ____

____ ____________________

Signature of Patient or Personal Representative* Date

Before a child reaches the age of majority, which is 18 years old. He/She cannot legally exercise their rights granted by the HIPAA Privacy Rule. Minors' parents or guardians act as their personal representatives.

Please note: *Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits.*

GAILMARD EYE CENTER

630 Ridge Road | Munster, IN 46321 | P: 219.836.1738 | F: 219.836.2822 | GailmardEyeCenter.com

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND HIPAA RELEASE

By signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.
- This Authorization is in effect until I revoke it by contacting Gailmard Eye Center

Name of Patient (Please print): ____

I authorize the release of medical and financial information, including: diagnosis, bills and exams. This may be released to the following below until revoked.

Spouse:____

Doctor:____

Other:____

____ ______________

Signature of Patient or Personal Representative* Date

**Before a child reaches the age of majority, which is 18 years old. He/She cannot legally exercise their rights granted by the HIPAA Privacy Rule. Minors' parents or guardians act as their personal representatives.*

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Gailmard Eye Center has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

References Available on the Internet:
https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html