WELCOME TO THE GAFFNEY EYE CLINIC
BARRY M. GAFFNEY O.D. P.A.
JEREMY H. GAFFNEY O.D.
DANIEL G. GAFFNEY O.D.

DATE_____

PATIENT'S NAME MR / MISS / MRS / MS _____

DATE OF BIRTH_____AGE_____

SOCIAL SECURITY NUMBER_____

MAILING ADDRESS_____

CITY_____STATE____ZIP_____HOME PHONE( )_____

EMPLOYER_____ WORK PHONE( )_____

OCCUPATION_____HOW LONG_____ CELL PHONE ( )_____

CONTACT PREFFERENCE HOME ☐ WORK ☐ CELL PHONE ☐

ETHNICITY _____RACE_____

E-MAIL ADDRESS_____

PRIMARY LANGUAGE_____ MARITAL STATUS_____

NAME OF SPOUSE_____PARENTS (IF CHILD)_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

PRIMARY CARE PHYSICIAN _____

INSURANCE INFORMATION (VISION & HEALTH)

INSURANCE COMPANY_____

POLICY #_____GROUP #_____

SUBSCRIBER NAME (MEMBER)_____

BIRTHDATE_____SS#_____

GAFFNEY EYE CLINIC

CURRENT OFFICE POLICIES

1. ***I understand I am financially responsible for all charges not covered by my insurance company.***
2. If we cannot verify your insurance on your first office visit, you are responsible for payment in full at the time of visit.
3. If you are on an HMO Plan, you must have prior authorization for your visit or your appointment will be rescheduled. If you do not wish to reschedule your appointment you must pay in full at the time of the visit.
4. Any insurance copays must be paid at the time of office visit. Also, any patient's portion of the bill, for example 80/20% of your co-ins will be collected at time of visit.
5. Self-pay patients must pay in full at the time services are rendered.
6. If there is any balance owed for an extended period of time there may be a monthly finance charge added to your outstanding balance. If you default on your payments it will be sent to a billing company or collection agency.
7. If your insurance company requests any information, second policies, injury reports, etc. the responsible party must cooperate with the insurance company in a timely manner or be fully responsible for the bill.
8. There is a $35.00 return check fee for any returned checks.
9. We do not give any medical information over the phone as required by law.
10. Minor children must have a guardian or parent present during the visit or a note giving permission for the doctor to see the patient without the parent or guardian present.
11. We will file your secondary insurance per your request, though be aware it is not done automatically

I _____hereby have read and fully understand these policies and will abide by them.

_____ Date: _____ _____

Patients Signature/Parent Signature (if patient is a minor) ***Witness***

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make any payable benefits to Gaffney Eye Clinic, and a photocopy of this assignment shall be considered as effective and valid as the original.
I authorize the doctor to initiate any complaints to the Insurance Commissioner for any reason on my behalf.

SIGNATURE OF POLICYHOLDER: _____ **DATE:** _____

MEDICARE LIFETIME SIGNATURE AUTHORIZATION

I request payment of authorized Medicare benefits to be made on my behalf. I assign the benefits payable to physician services to the physician or organization furnishing the services. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

Date: _____ Signature: _____

GAFFNEY EYE CLINIC

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I _____ _____
Patient Name Parent or Guardian Name if Minor

Acknowledge that I have received a copy of the Notice of Privacy Practices from
DR. BARRY M. GAFFNEY OD PA / DR. JEREMY H. GAFFNEY OD / DR. DANIEL G. GAFFNEY OD

By signing this form, I authorize ***DR. BARRY M GAFFNEY OD PA / DR. JEREMY H. GAFFNEY OD / DR. DANIEL G. GAFFNEY OD*** to release my Medical and Billing Information to the listed individuals: I am aware that I can revoke the Authorization for any individual at any time, but must do so in writing.

The following individuals have my authorization to access my Protected Health Information, and to pick up: Prescriptions, Glasses, Contact Lenses, Etc..

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Gaffney Eye Clinic may leave appointment information on my :

Home ☐ Yes ☐ No

Cell ☐ Yes ☐ No

Email ☐ Yes ☐ No **Email:** _____

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Patient/ Guardian if Minor **Date**

INFORMATION REGARDING DILATING EYE DROPS

DILATION IS THE STANDARD OF CARE TO ALLOW THOROUGH EVALUATION OF EYE TISSUE FOR A NUMBER OF EYE CONDITIONS. The use of dilation drops temporarily increases the size of your pupils, which allows an eye physician to more accurately investigate the health of your eyes. Dilation drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected, and because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. For a short time, wearing sunglasses may be a necessary comfort. Adverse reactions, such as acute angle-closure glaucoma, may also be triggered and/or diagnosed by the dilating drops. Call our office immediately if you experience excessive pain, discomfort, nausea, or any other untoward symptoms. Thank you for your assistance during this important procedure.

By signing this form I hereby acknowledge that I am aware of the above information and authorize my physicians and/or their assistants to administer dilating eye drops to assist in the optimum evaluation of my eyes. My acknowledgement and authorization shall be without expiration, but I am aware that (as all other diagnostic or treatment procedures) **AT ANY TIME I MAY ELECT TO NOT HAVE THIS IMPORTANT PROCEDURE BY SIMPLY INFORMING THE TECHNICIAN AND/OR PHYSICIAN.** If I elect to not use dilating drops for my examination, I also hereby affirm that I am aware that my decision may reduce the ability of my physician to optimally care for my eyes.

X_____ _____

Signed by patient
(or person authorized to sign for patient)

Date

MEDICAL HEALTH HISTORY

Name: _____ Birthdate: _____ Age: _____ Date: _____

❖ PAST EYE HISTORY

Last eye exam: _____ Name and location of Eye Doctor: _____ Type of treatment: _____

Do you wear: Glasses? ☐ Yes ☐ No Last Worn: _____ Contact Lenses? ☐ Yes ☐ No Last Worn: _____

Have you ever been diagnosed with any of the following eye problems:

DISEASE/CONDITION	SELF YES	NO	EXPLAIN
Injury	☐	☐	_____
Surgery	☐	☐	_____
Disease	☐	☐	_____
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Strabismus	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other_____	☐	☐	_____

MEDICATIONS: NONE ☐

Family Medical History Has anyone in your blood related family (parents, grandparents, siblings, children;(living or deceased) ever been diagnosed with any of the following conditions:

DISEASE/CONDITION	YES	NO	RELATION
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Nerve Condition	☐	☐	_____
Thyroid Disease	☐	☐	_____

EYE PROBLEMS	YES	NO	RELATION
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Strabismus	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other	☐	☐	_____

Name and Location of Medical Doctor: _____ Dr.'s Phone: _____

Name and Location of Specialist Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: _____

Do you have allergies to medications? ☐ Yes ☐ No If yes, explain : _____

Do you have allergies to non-medication items? ☐ Yes ☐ No If yes, explain: _____

List Major injuries, surgeries and /or hospitalizations you have had: _____

_____

_____

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes, I would prefer to discuss my social History information with my doctor. (Check Box) ☐

Employer or School: _____ Occupation/School _____

What Hobbies or avocations do you have? _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently breast feeding? ☐ Yes ☐ No

If you take any medications that correspond with any of the following medical conditions please list on the line next to YOUR condition.

Constitution None ☐
- ☐ Developmental disability: _____
- ☐ Fatigue: _____
- ☐ Trauma: _____

- ☐ Weightloss/gain: _____
- ☐ Other: _____

Integumentary None ☐
- ☐ Eczema: _____
- ☐ Psoriasis: _____
- ☐ Rosacea : _____
- ☐ Other: _____

Neurological None ☐
- ☐ Headache: _____
- ☐ Migraine : _____
- ☐ Multiple Sclerosis : _____
- ☐ Seizures : _____
- ☐ Stroke Damage: _____
- ☐ Other: _____

Ear, Nose, Throat None ☐
- ☐ Dry Throat/Mouth : _____
- ☐ Hearing Loss : _____
- ☐ Sinus Drainage: _____
- ☐ Other : _____

Respiratory None ☐
- ☐ Asthma : _____
- ☐ Bronchitis : _____
- ☐ Emphysema : _____
- ☐ Lung Cancer : _____
- ☐ Other : _____

Gastrointestinal None ☐
- ☐ Crohn's : _____
- ☐ Diarrhea : _____
- ☐ Hiatal Hernia : _____
- ☐ Reflux : _____
- ☐ Ulcer: _____
- ☐ Other : _____

Endocrine None ☐
- ☐ Hormonal : _____
- ☐ Thyroid : _____
- ☐ Diabetes : _____

First Diagnosed: _____
Last Check- Up: _____
Family With : _____
A1C: _____
☐ Other _____

Cardiovascular None ☐
- ☐ Heart Disease : _____
- ☐ Hypertension : _____
- ☐ Stroke : _____

- ☐ Vascular Disease : _____
- ☐ Other : _____

Hematological/Lymphatic None ☐
- ☐ Anemia: _____
- ☐ Cholesterol : _____
- ☐ Leukemia : _____
- ☐ Triglycerides : _____
- ☐ Other : _____

Psychiatry None ☐
- ☐ Alzheimer's : _____
- ☐ Depression : _____
- ☐ Nerve condition: _____
- ☐ Panic Disorder : _____
- ☐ Psychosis : _____
- ☐ Other : _____

Genitourinary None ☐
- ☐ Genital : _____
- ☐ Kidney Ailments : _____
- ☐ Urinary Tract Infections : _____
- ☐ Other : _____

Musculoskeletal None ☐
- ☐ Ankylosing Spondylitis : _____
- ☐ Fibromyalgia : _____
- ☐ Muscular Dystrophy : _____
- ☐ Osteoarthritis : _____
- ☐ Other : _____

Allergic/Immunologic None ☐
- ☐ Drug Allergy : _____
- ☐ Environmental Allergy: _____
- ☐ Lupus : _____
- ☐ Rheumatoid Arthritis : _____
- ☐ Sarcoid : _____
- ☐ Other : _____

Gaffney Eye Clinic Dry Eye Questionnaire

1. Questions about **EYE DISCOMFORT:**
   a. During a typical day in the past month, **how often** did your eyes feel discomfort?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

   b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

2. Questions about **EYE DRYNESS:**
   a. During a typical day in the past month, **how often** did your eyes feel dry?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

   0
   b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

3. Questions about **WATERY EYES:**
   During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Score:

					TOTAL