Lowcountry Eye Specialists

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ **Email:** _____ **practices are required to obtain this to offer patients a web portal.*

Preferred Ph #: (_____) _____-_____ **Secondary Ph #: (_____) _____-_____**

Circle: cell / home / work **Circle:** cell / home / work

** **OK to leave a voicemail and/or text message with detailed information?** Cell Home Work Email None

Emergency Contact Name: _____ **Relationship:** _____ **Ph #:** _____

DEMOGRAPHICS

(The American Recovery & Reinvestment Act of 2009 requires practices to use Electronic Health Records and collect this data for statistical purposes only.)

Gender: Male / Female **Marital Status:** Single / Married / Other: _____

Race: American Indian or Alaska Native / Black / White / Asian / Native Hawaiian or Pacific Islander / Other

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino **Preferred Language:** English / Spanish / Other

Employment Status: Employed / Student / Homemaker / Retired / Disabled / Unemployed

INSURANCE

Primary Insurance: _____ **ID#:** _____ **Subscriber DOB:** _____

Secondary Insurance: _____ **ID#:** _____ **Subscriber DOB:** _____

Tertiary Insurance: _____ **ID#:** _____ **Subscriber DOB:** _____

REFERRAL SOURCE & OTHER PROVIDERS

Primary Care Physician: _____ **Eye Care Physician:** _____

Specialty Doctors & Diagnosis: _____

_____

Who referred you? / How did you hear about us? _____

Patient or Guarantor's Signature: _____ **Date:** _____

Print Name of above signature if other than patients: _____ **Relationship:** _____

Lowcountry Eye Specialists
Communication Authorization

Patient Name:_____DOB:_____

Initial here_____if you do not want your healthcare information discussed with anyone other than yourself.
If you would like us to discuss your healthcare information (e.g. test results, prescription information etc.) with anyone other than yourself (spouse, family members), please list below any individuals whom you authorize.

Purpose of request- I authorize **LOWCOUNTRY EYE SPECIALISTS** to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information? (list the individual/entity who is to receive your information)

Name_____ Relationship to patient _____

Name_____ Relationship to patient _____

Name_____ Relationship to patient _____

Name_____ Relationship to patient _____

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

All of my past, present and future health information

OR

All of my past, present, and future health information with the exception of the following information:

Mental health records — Alcohol/drug abuse treatment

Communicable diseases (including HIV and AIDS) — Other (please specify):_____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request — Other (please specify)_____

This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person (s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Please sign the next available signature line below

Patient Signature _____ Date_____

(Form created May 2015 / updated 04-17-18)

You have the right to receive a copy of signed authorizations upon request

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DILATION

Dilating drops are used to dilate or enlarge the pupil of the eye. This is necessary for the doctor to perform a complete examination of the retina and the back of the eye. Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after your examination. If you feel that you cannot safely drive after being dilated, we recommend that you make alternative transportation arrangements. However, a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide for you after your dilation. Please be cautious and determine what is best for you.

REFRACTION

A refraction is a diagnostic test used to determine the best possible visual acuity and function of your eye. It is a critical part of any complete eye exam and MUST be done if you are here for a cataract evaluation, have any vision complaints, experience a change in your vision, and/or you would like a prescription for glasses.

As indicated by the federal government, a refraction is a non-covered service by most medical insurance plans including Medicare and Medicaid as they consider this a "vision" service, not a "medical" service. The fee for a refraction is **$45.00** and is collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. If you do not want this test done, please notify the technician during your exam.

*If you are here for a cataract evaluation and have had a refraction within 90 days, we will attempt to get a copy of it from your Optometrist, so you don't have to have it repeated.

PRACTICE POLICIES

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Our doctor(s) will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

We value our patients and make every effort to have your visit be a pleasant experience with minimum waiting times. Please be aware you may be asked to reschedule your visit for any of the following:

- Arriving more than 15 minutes late for your appointment
- Taking more than 15 minutes to fill out paperwork
- Disturbing other patients with loud cell phone calls, un-attended children etc…
- Unwilling to complete and sign paperwork, produce verifiable insurance or photo ID
- Unable to pay past due balances, co-pays, deductibles, co-insurance or self-pay amounts due at time of service.

Your health is our number one concern, however we require you to be active participants in your care. Please be aware you may be discharged from the practice, for any of the following:

- Verbally abusive, threatening or violent behavior
- Frequently failing to show up for appointments or rescheduling at the last moment
- Non-compliance to a prescribed treatment plan
- Changing to an insurance plan that we do not participate with
- Unresolved past due balances, or failure to meet payment schedules

I, the undersigned patient/guarantor, certify that I have active coverage with the above insurance companies and assign directly to LCeyes physicians all insurance benefits, if any, otherwise payable to me for services rendered. **I UNDERTSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT, PAID BY INSURANCE.** I understand it is my responsibility to ensure network participation and obtain any authorizations that may be required by my insurance in order to receive maximum benefits. I understand all **COAYS** are due and payable at the time of service and agree to pay an applicable **CO-INSURANCE** and **DEDUCTIBLE** amounts not collected at the time of service, within 30 days, unless I have made prior arrangements for a payment plan with office staff. Please contact your insurance company to fully understand you benefits and your financial responsibilities for the services

Acknowledgment: By signing below I acknowledge that I have read and understand the above information.

Patient Signature: _____ **Date:** _____

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PAST MEDICAL HISTORY

Patient Name: _____ DOB: _____

Today's Date: _____

Personal Ocular History

Last eye exam date: _____

Do you wear glasses?

Yes ◯ No ◯ If yes, how old are they? _____

Do you wear contact lenses?

Yes ◯ No ◯ If yes, what brand are they? _____

How old is your current pair? _____

How many years have you worn contact lenses? _____

Do you have any of the following vision concerns?

☐ Blurry Vision	☐ Frontal Headache	☐ Double Vision
☐ Eyestrain	☐ Poor Night Vision	☐ Distorted Vision
☐ Severe Sensitivity to Light	☐ Glare	☐ Fluctuating Vision

Please list any additional vision concerns: _____

Do you have any of the following eye health concerns?

☐ Redness	☐ Tearing/Watering	☐ Eye Pain
☐ Burning	☐ Discharge	☐ Eye Soreness
☐ Itching	☐ Dryness	☐ Flashes and/or Floaters

Please list any additional eye health concerns: _____

Have you ever been diagnosed with any of the following ocular conditions?

☐ Cataracts	☐ Keratoconus	
☐ Glaucoma	☐ Lazy Eye	☐ Contact Lens Overwear
☐ Macular Degeneration	☐ Dry Eye	☐ Retinal Condition
☐ Diabetic Retinopathy	☐ Eye Infection/Inflammation	☐ Eye Trauma/Injury

Please list any additional diagnosed ocular conditions: _____

Have you ever had any ocular surgeries?

Yes ◯ No ◯ If yes, please list: _____

Family History:

Please list parents, grandparents, siblings, or children – living or deceased – with the following conditions:

Glaucoma: _____	Diabetes: _____
Lazy Eye: _____	Heart Disease: _____
Macular Degeneration: _____	High Blood Pressure: _____
Color Blindness: _____	Kidney Disease: _____
Retinal Detachment: _____	Lupus: _____
Keratoconus: _____	Thyroid Disease: _____

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PAST MEDICAL HISTORY

Review of Systems

Please mark beside any condition you currently have.

Constitutional
☐ Developmental Disabilities
☐ Cancer
Type: _____
☐ Unintentional Weight Loss
☐ Pregnant

ENT
☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis

Neurological
☐ Multiple Sclerosis
☐ Epilepsy
☐ Cerebral Palsy
☐ Tumor
☐ Stroke/CVA
☐ Migraine

Psychological
☐ Depression
☐ Attention Deficit
☐ Anxiety Disorder
☐ Bipolar Disorder

Cardiovascular
☐ Hypertension
☐ Stroke/CVA
☐ Heart Disease
☐ Vascular Disease
☐ Congestive Heart Failure

Respiratory
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic Obstruction
☐ Sleep Apnea

Gastrointestinal
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease

Genitourinary
☐ Kidney Disease
☐ Prostate Disease/Cancer

Musculoskeletal
☐ Arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Ankylosing Spondylitis
☐ Osteoporosis
☐ Gout

Dermatological
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes Simplex/Cold Sores
☐ Herpes Zoster/Shingles

Endocrine
☐ Type 2 Diabetes Mellitus
☐ Type 1 Diabetes Mellitus
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction

Hematologic/Lymphatic
☐ Anemia
☐ Large-Volume Blood Loss
☐ Ulcer
☐ High Cholesterol

Allergic/Immune
☐ Environmental Allergies
☐ Rheumatoid Arthritis
☐ Lupus
☐ Sjogren's Syndrome

Pharmacy Name: _____ **Pharmacy Address:** _____

I ☐ do or ☐ do not give permission to obtain my medication history from my pharmacy.

Current Prescription a id Non-Prescription Medications (Including Eye Drops):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medication: _____

Surgical History: _____

_____

Social History

Occupation: _____ Pregnant? _____

Tobacco Use: _____ Alcohol Use: _____ Street Drug Use: _____

Have you received the flu vaccine? _____ Have you received the pneumonia vaccine? _____