WELCOME TO OUR OFFICE

Personal Information

Patient name________________________ Email________________________

Address________________________ City______________ State_______ Zip_________

Social Security Number________________________ Birth Date________________________

Home Phone Number_______________ Cell Phone_______________ Work Phone_______________

You or your parent's employer________________________ Occupation________________________

Hobbies____

Other family members who are our patients ________________________________

How did you learn of our office?________________________________

Vision Insurance Information

Name of Insured________________________ Relationship to Insured________________________

Name of Insurance Company________________________ Employer________________________

Insured's Date of Birth_______________ Member ID#_______________ Group#_______________

Primary Medical Insurance Information

Name of Insured________________________ Relationship to Insured________________________

Name of Insurance Company________________________ Employer________________________

Insured's Date of Birth_______________ Member ID#_______________ Group#_______________

Insurance Address________________________ City______________ State______ Zip__________

Secondary Medical Insurance Information

Name of Insured________________________ Relationship to Insured________________________

Name of Insurance Company________________________ Employer________________________

Insured's Date of Birth_______________ Member ID#_______________ Group#_______________

Insurance Address________________________ City______________ State______ Zip__________

Authorization

I authorize this office to release any information, including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my insurance company may pay less than the actual bill for the services and agree to be responsible for payment of all service rendered on my behalf of my dependents. I also authorize this office to send my pertinent vision information (i.e. recalls, etc.) to the above address and email address.

X____ Date________________________

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Sullivan | Ostoich
eye center

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name______________________ First Name__________________ MI____ Birth Date________________

Vision History

Date of last exam____________________ Name of eye doctor____

Do you currently wear glasses?_________ When do you wear glasses? (Please circle all that apply)

All the time Work Safety Reading/Near work Distance only Computer work other________

Have you ever worn contacts?_______ Type?______________ Are you interested in contacts?__________

Have you had LASIK surgery?___________ Are you interested in LASIK surgery?________________

Personal Eye Information

Do you have any eye condition or problems? ____ Yes ____ No What kind?___________________________

Have you had any eye operations? ____Yes ____No Type___________________ Date___________________

Have you had any eye injuries? ____ Yes ____ No Kind_____________________ Date___________________

Have you been diagnosed with any of the following? (please circle all that apply)

Glaucoma Cataracts Macular Degeneration Retinal Detachment

Additional Information ____

Medical Information

Do you have problems with any of these systems? (please circle if applicable to you)

Gastrointestinal	Nervous	Endocrine (glands)
Ears/Nose/ Throat	Blood/Lymph	Urinary
Cardiovascular	Muscle/ Bones	Allergic/Immunologic
Respiratory	Skin	Headaches
High Blood Pressure	Eyes	Mental

Please Explain____

Have you been diagnosed with diabetes? Yes No Type_____________ Date of diagnosis________________

Allergies to any medications? Yes No Which?____________________ Reactions?_____________________

Other health problems?____

Current Medications?____

Have you had any operations?__________ What kind?______________________ When?_________________

Name of Primary Care Physician____________________________ Last Physical_________________________

Family History

High Blood Pressure	__ yes __ no	Relation_______	Macular Degeneration	__yes __ no	Relation _____
Diabetes	__ yes __ no	Relation_______	Retinal Detachment	__yes __ no	Relation_____
Glaucoma	__ yes __ no	Relation _______	Cataracts	__yes __ no	Relation_____

Doctor Use Only

Reviewed by_____________ Date______________ Reviewed by_____________ Date______________

Reviewed by_____________ Date______________ Reviewed by_____________ Date______________

Reviewed by_____________ Date______________ Reviewed by_____________ Date______________

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Medical Test Authorization

Digital Retinal Imaging is a new technology that allows instant viewing of retinal images by the doctor and patient. This computerized technology helps us by establishing baseline images of the inside of your eyes. We can then compare this image with future images and carefully observe any normal or abnormal vision conditions such as glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions, which can result in permanent vision loss if not caught and treated in a timely manner.

We **strongly** encourage all of our patients to receive these medical tests yearly. It is especially important for patients who have:

- Headaches
- Spots or Flashes of light
- Circulatory problems
- Eye pain
- History of high blood pressure
- History of diabetes
- Family history of eye disease
- Strong eyeglass prescriptions

Please check the appropriate line below and sign at the bottom.

______ Yes, I do wish to have the digital retinal images taken of the back of my eyes today. I understand there is a $35.00 charge, which is not covered by insurance.

______ No, I DO NOT wish to have the above medical tests today. I understand the doctors' recommendations but decline at this time.

Patient's Signature:_______________________________________ Date:____________________

<u>For Dr. Sullivan & Dr. Mata Patients:</u>

I understand that my exam today will be submitted to my Medical Insurance, NOT any Vision Insurance Plans. _________________ (Initials)

Acknowledgement of receipt of Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

I, ____, Have received the NOTICE OF PRIVACY PRACTICES from Sullivan- Ostoich Eye Center, LTD.

I do NOT object to :

Phone calls to my home_____, place of employment _____, cell _____

Messages left on my answering machine/ voicemail_____

Messages left with someone in my household _____

Please note: All mail will be sent to your home address and no information will be faxed or emailed to you or others without your written permission.

____ ________________________________

Signature of Patient or Legal Guardian Date