EASTERN EYE ASSOCIATES O.D., P.A.

PATIENT INFORMATION

(PLEASE PRINT)

DIABETIC: ☐ Yes ☐ No

Patient's Full Name: ____

Sex: ☐ M ☐ F Birthdate: ______ /______ /________ Age: ________ SSN: _____ - ____ - ______

Mailing Address: ____

City: ______________________________ State: __________ Zip: ____________

Home Phone: (_______) ______________ Cell Phone: (_______) ______________

Email Address: ____

Ethnicity: ☐ White ☐ African American ☐ Asian ☐ Latino ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: ____

Spouse's D.O.B. ______ /______ /_________ Spouse's SSN: ______ - ______ - _______

Referring Doctor: ______________________________ City: __________________

Family Doctor: ______________________________ City: __________________

Emergency Contact: ______________________________ Phone: (_____) ___________

FINANCIAL POLICY

I hereby authorize my insurance benefits to be paid directly to Eastern Eye Associates, O.D., P.A., realizing I am responsible for payment of all non-covered services, and I hereby authorize the release of pertinent medical information to insurance carrier(s) as may be requested from time to time.

We want to thank you in advance for your cooperation and assistance in helping us hold down increasing costs.

______________________________ ____________________

Patient Signature Date

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

Name: ______________________________ Relationship: ____________________

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Eastern Eye Associates, O.D., P.A., unless and until I notify Eastern Eye Associates, O.D., P.A. in writing of any changes.

______________________________ ______________________________
Patient Signature Date

____
Print Name

____
Relationship of Representative to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operation purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S 8-53, and HIPAA allow verbal authorization consent for release, respectively, of information to family members. However, the better practice is to document patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent authorization to release PHI to other providers or to insurance companies or others, since most providers already have forms. The contents of this form can be combined with such existing consent forms.

MEDICAL HISTORY QUESTIONNAIRE

Current Occupation: ______________________________

Years Employed: __________ Employer: ______________________________

SPECTACLE LENS HISTORY

Do you use a computer? ☐ Yes ☐ No How many hours a day? ______________

Do you drive? ☐ Yes ☐ No Mileage per day? ______________

Do you have glare problems? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since: ______________

Type of glasses: ☐ Full-Time ☐ Part-Time ☐ Distance ☐ Close

☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ☐ Yes ☐ No ______________

Do you wear sunglasses? ☐ Yes ☐ No

Are your sunglasses your current prescription? ☐ Yes ☐ No

SPECIAL EYEWEAR NEEDS

☐ Computer (prescriptions, anti-glare) ☐ Safety (gardening, welding, etc.)

☐ Occupational (mechanics, pilots, etc.) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

What was your reason for stopping? ______________________________

Do you currently wear contact lenses? ☐ Yes ☐ No Since: ______________

Type and brand of contact lenses: ______________________________

How many hours a day? _________ Days per week? _________ Today's wearing time? ______________

If not a contact lens wearer, would you consider contact lenses at this time? ☐ Yes ☐ No

Please rate the following on a scale of 1 – 10, with 1 being POOR and 10 being EXCELLENT.

Lens Comfort: (R:______ L:______) Distance Vision: (R:______ L:______) Near Vision: (R:______ L:______)

Which solutions do you use?

Cleaner: ____________________ Disinfectant: ____________________ Enzyme: ____________________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack

Smoking Status: ______________________________

Method of Tobacco Intake: ☐ Smoking ☐ Chewing

Do you use illegal drugs? ☐ Yes ☐ No

Hobbies/Interests: ______________________________

Last Health Exam: ______________________________

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name: ______________________________

Address of Primary Care Physician: ______________________________

City: ____________________ State/ Zip: ______________ Phone: ______________

REFERRING PHYSICIAN

Referring Physician and Clinic Name: ______________________________

Address of Primary Care Physician: ______________________________

City: ____________________ State/ Zip: ______________ Phone: ______________

HEALTH HISTORY

What is the main reason for today's exam? ______________________________

When was your last exam? ____________

When was your last health exam? ______________________________

Past Illnesses or Injuries: ______________________________

Past Surgeries: ______________________________

Current Medications: ______________________________

Current Eye Drops: ______________________________

Medications that cause reactions or sensitivities: ______________________________

Specific Allergies: ______________________________

EYE HISTORY

Condition	Response	Condition	Response	Condition	Response
Glaucoma	☐ Yes ☐ No	Dryness	☐ Yes ☐ No	Strabismus (Cross Eye)	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Tearing/Watering	☐ Yes ☐ No	Blurred Vision	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Pain or Soreness	☐ Yes ☐ No	Distance	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	Foreign Body	☐ Yes ☐ No	Blurred Vision Near	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Infection	☐ Yes ☐ No	Distorted Vision	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Itching	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Glare/Light Sensitivity	☐ Yes ☐ No	Discharge	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Tired Eyes	☐ Yes ☐ No	Drooping Eyelid	☐ Yes ☐ No	Fluctuating Vision	☐ Yes ☐ No
Amblyopia (Lazy Eye)	☐ Yes ☐ No	Redness	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Burning	☐ Yes ☐ No	Sandy or Gritty	☐ Yes ☐ No	Loss of Side Vision	☐ Yes ☐ No

GENERAL HEALTH CONDITION

Condition	Response	Condition	Response	Condition	Response
Fever	☐ Yes ☐ No	Respiratory (Asthma)	☐ Yes ☐ No	Anxiety or Depression	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No	Gastrointestinal	☐ Yes ☐ No	Thyroid/Diabetes	☐ Yes ☐ No
Other Symptoms	☐ Yes ☐ No	Kidney	☐ Yes ☐ No	Blood/Lymph	☐ Yes ☐ No
Ear, Nose, Throat	☐ Yes ☐ No	Muscles, Bones	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Skin	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
		Neurological	☐ Yes ☐ No	Nursing	☐ Yes ☐ No

FAMILY HISTORY

Condition	Response	Condition	Response	Condition	Response
Amblyopia (Lazy Eye)	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	Strabismus (Eye Turn)	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Cataract(s)	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Others	☐ Yes ☐ No