HARDIN VALLEY EYECARE & Optical

For Office Use: 1 2 3 4 5
GIx CL OV SP IN
RTA W FULL
RTO 1 2 3 4 5 6 w m y
rx dil glau dry rta vf cat ov

Welcome to the HVEO Family

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Sex: **M / F** Email Address: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** Home Phone: _____ Work Phone: _____

Cell Phone: _____ How were you referred to our office? _____ Do you have a facebook account? Yes No

Marital Status: **Single** **Married** **Other** ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured Social Security Number: _____

Insured's Birth Date:_____ Insured's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offerred a copy of Hardin Valley Eyecare & Optical's statement on privacy practices.
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Hardin Valley Eyecare & Optical to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Hardin Valley Eyecare & Optical to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection of past-due balances.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. **Medical Insurance will only cover** if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Loss of vision	**Floaters**	**Eye pain/soreness**	**Glare**	**Dry eyes**
Blurred vision	**Crossed eyes**	**Watery eyes**	**Light sensitivity**	**Red eyes**
Double vision	**Flashes of light**	**Sandy/gritty feeling**	**Tired eyes**	**Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* **Right** **Left** **Both**
Quality *How is it effecting you?* **Bothersome** **Aware** **Painful**
Severity *How severe is the problem?* **Mild** **Moderate** **Severe**
Duration *How long have you had the problem?* _____

Timing *Is it new, ongoing, returning?* **New** **Ongoing** **Returning**
Context *Associated w/:* **Infection** **Medical condition** **Injury** **Surgery**
Modifiers *Previous treatment?* **Drops** **Medication** **Other:** _____
Symptoms *Are there associated symptoms?* **Headache** **Other:** _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
No problems **Diabetes** **High blood pressure** **Cancer**

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
No problems **Glaucoma** **Amblyopia** **Cataracts** **Macular degeneration** **Strabismus (eye turn)**

SOCIAL HISTORY

Do you smoke? **Y N**
If yes, what do you smoke? **Cigarettes Cigars Pipes**
How much per month do you smoke? _____

Do you consume alcohol? **Y N**
If yes, how much do you drink? _____

What is your occupation? _____

CURRENT VISION

Glasses: Do you currently wear glasses? **Y N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? **Single vision Bifocal Trifocal No-line (Progressive)**

Contacts: Do you want to be fitted/evaluated for contact lenses today? **Y N** Would you like to discuss your options for wearing contact lenses today? **Y N**

Do you currently wear contact lenses? **Y N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? **Soft Rigid**
What is the manufacturer/model of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ **Months / Years**
How often do you replace your contact lenses? **Daily Weekly 2 weeks Monthly 3 months 6 months Annually**
What solutions do you use to care for contact lenses? **Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other:** _____

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder **Y NG**
- Surgery **Y N**
- Glaucoma **Y N**
- Amblyopia (lazy eye) **Y N**
- Cataract **Y N**
- Retinal problems **Y N**
- Macular degeneration **Y N**
- Strabismus (eye turn) **Y N**
- Patching **Y N**
- Other _____

Constitutional Problems
- Cancer **Y N**
- Fatigue **Y N**
- Developmental disability **Y N**
- Other _____

Ears, Nose, Mouth, Throat Problems
- Laryngitis **Y N**
- Dry mouth **Y N**
- Hearing loss **Y N**
- Sinusitis **Y N**
- Other _____

Neurological Problems
- Cerebral palsy **Y N**
- Multiple sclerosis **Y N**
- Tumor **Y N**
- Epilepsy **Y N**
- Other _____

Psychiatric Problems
- Depression **Y N**
- Other _____

Cardiovascular Problems
- Vascular disease **Y N**
- Stroke **Y N**
- Congestive heart failure **Y N**
- Heart disease **Y N**
- High blood pressure **Y N**
- Other _____

Respiratory Problems
- Emphysema **Y N**
- Bronchitis **Y N**
- Smoker **Y N**
- COPD **Y N**
- Asthma **Y N**
- Other _____

Gastrointestinal Problems
- Colitis **Y N**
- Chron's disease **Y N**
- Ulcer **Y N**
- Other _____

Genitourinary Problems
- Prostate disease/cancer **Y N**
- STD **Y N**
- Kidney disease **Y N**
- Other _____

Musculoskelatal Problems
- Ankylosis spondylitis **Y N**
- Fibromyalgia **Y N**
- Muscular dystrophy **Y N**
- Osteoarthritis **Y N**
- Other _____

Skin Problems
- Rosacea **Y N**
- Psoriasis **Y N**
- Eczema **Y N**
- Other _____

Endocrine Problems
- Insulin dependent diabetes **Y N**
- Hormonal dysfunction **Y N**
- Thyroid dysfunction **Y N**
- Non-insulin diabetes **Y N**
- Other _____

Blood/Lymph Problems
- Large volume blood loss **Y N**
- Anemia **Y N**
- Other _____

Allergy/Immunologic Problems
- Environmental allergies **Y N**
- Rheumatoid artheritis **Y N**
- Drug allergies **Y N**
- Lupus **Y N**
- Other _____

Do you sometimes experience dry eyes? **Y N**

Are your eyes sensitive to sunlight? **Y N**

Do you work at a computer ? **Y N**

Problems with reflections and/or glare? **Y N**

Prefer not to wear your glasses at times? **Y N**

Interested in newer contact lens technology? **Y N**

Want information on thinner / lighter lenses? **Y N**

Like information on LASIK vision surgery? **Y N**

Like a non-surgical option to correction? **Y N**

Participate in sporting activities / hobbies?

_____

List any medications you are currently taking:

_____

_____

_____

_____

List any medicine allergies:

_____

List any other allergies:

_____

_____

Are you currently pregnant or nursing? ***Y N***

HARDIN VALLEY EYECARE & Optical

HIPAA Notice

I have read and understand the HIPAA privacy notice (please sign below):

_____ Date _____

Dilation

Dilation is a necessary component of every comprehensive eye examination. It requires the use of some eye drops that temporally increase the size of your pupil, which in turn, allows your eye doctor to examine the back of the eye in its entirety. It takes about 15- 20 minutes for the drops to take effect. Near vision will be blurry for a few hours along with an increased sensitivity to light. Distance vision is **NOT** relatively affected, except for the sensitivity to light.

Dilation aids in the detection of certain eye conditions like glaucoma, cataracts, macular degeneration, retinal problems, and many more to list.

If you have a systemic condition like diabetes, high blood pressure, or have been diagnosed with an eye condition or with a family history of an eye condition, it is recommended annually. It is also recommended if you have a high glasses prescription.

Please **check one** of the following:

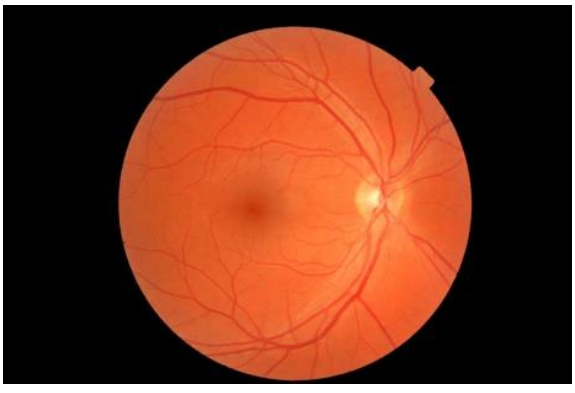
____ I want to have my eyes dilated or give permission to dilate my child's eyes.
____ I understand the importance of dilation and will schedule it for another day.

Please sign and date:

Name: _____ Date: _____

Retinal Scan & Optic Nerve Analysis

Retinal and optic nerve health is vital in maintaining good vision. This scan can detect early signs of glaucoma, macular degeneration and many other eye diseases. The **fee for this screening is $25.00** which is **not** covered by vision benefits**. It provides excellent base-line information for future reference.**



Highly recommended if you have the following:

Diabetes
High Blood Pressure
Family history of Glaucoma
Family history of Macular Degeneration
Any other Retinal problems

___ I want to have this done for better eye health monitoring
___ I do not want to have this done at this time