

PATIENT PREFERRED NAME: _____ DATE: ____ / ____ / ____



PATIENT INFORMATION

Last Name: _____

First: _____ MI: _____

Date of Birth: ____ / ____ / ____ Age: _____

SSN: ____ / ____ / ____ Gender: M F

Address: _____

City _____ State ____ Zip _____

Preferred contact method: CALL CELL CALL HOME TEXT

Preferred Phone: _____
 CELL PHONE HOME PHONE

Alternate Phone: _____
 CELL PHONE HOME PHONE OTHER:

Email: _____
(for appointment confirmation, instructions, portal link)

Marital Status: Single Married Divorced
(Circle one) Widowed Separated Partnered

Race: African American American Indian/Alaskan Asian
Native Hawaiian/Islander White Other Unknown

Ethnicity: Hispanic/Latino Not Hispanic or Latino
Circle one Unknown Decline to specify

EMERGENCY CONTACT, PHYSICIAN, PHARMACY

Emergency Contact: _____

Emergency Contact Phone _____ Relation to patient _____

Do you have a Primary Care Physician (PCP)? **YES NO**

Name of PCP _____ **Location/Clinic** _____

Do you request a report sent to your PCP? **YES NO***
*We may send a report if insurance or coordination of care requires

List any other Physician/Specialist to send a report: _____

How did you hear about us or who referred you here? _____

Pharmacy: _____
Pharmacy name _____ **Crossroads/Zip** _____

Mail-Order Pharmacy: _____

Complete below & show **INSURANCE CARDS** & **photo ID**

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: * (Name of insurance)

→ Is patient primary insured? **YES NO**
If no, state Relation to Patient

Complete Section below for Primary Insured:

____ / ____ / ____
Last Name, First Name Social Security # (SSN)

____ / ____ / ____ Employment Status of Primary: *
Date of Birth (DOB) (Circle one) Employed Full-Time Part-time
Unemployed Disabled Retired Student

SECONDARY MEDICAL INSURANCE: (name of insurance)

→ Is patient primary on this plan? **YES NO**
If no, state Relation to Patient

Complete Section below for Primary Insured:

____ / ____ / ____
Last Name, First Name Social Security # (SSN)

____ / ____ / ____ Employment Status of Insured: (Circle)
Date of Birth (DOB) Employed Full-time Employed Part-time
Unemployed Disabled Retired Student

*We do **not** file VISION insurance. If you need a vision or contact lens exam, ask about our routine services at our South OKC location. *

DO YOU WANT A NEW GLASSES PRESCRIPTION TODAY?

YES NO

*\$35 Due at time of service unless this is a known covered benefit under your medical plan. This is not part of a medical eye exam and insurance requires a separate fee.

PAYMENT FOR SERVICES: AT **CHECK-IN**, we collect our best estimate of amount due. Fees for additional tests ordered will be collected at **CHECK-OUT**.

We participate with most insurance plans and adjust our fees to the "allowable." It is impossible for us to always know what your insurance will pay. Once your claim is processed, we send a bill for the remaining balance or refund for credit.

By signing below, you attest you have provided accurate information to the best of your knowledge and agree to the terms of service.

Signature of Patient or Guarantor

Date Signed

PATIENT NAME: _____ DATE: ____ / ____ / ____

MEDICAL AND OCULAR HISTORY

Reason for visit: _____

Any other eye/vision problems: _____

Have you EVER been diagnosed with any of the following? (Circle all that apply) NONE

Alzheimer's	CVA – Stroke	Heart Failure (CHF)	Rheumatoid Arthritis
Anxiety	Dementia	High Cholesterol	Rosacea
Arthritis	Emphysema / COPD	HIV / AIDS	Sleep Apnea / CPAP
Asthma	Epilepsy / Seizures	Kidney Disease / Dialysis	Tuberculosis
Bipolar Disorder	Headaches / Migraine	Lupus	Thyroid - Hyper (High) / Hypo (Low)
Bronchitis- Chronic	Heart Disease / Attack	Multiple Sclerosis	Vertigo

Cancer: _____ OTHER: _____

DIABETES? YES NO Date Diagnosed: _____ **HYPERTENSION? YES NO** Last Blood Pressure: _____

Last A1C: _____ Date: _____

IF YES, CIRCLE ALL THAT APPLY: Type 1 Type 2 On Insulin Diet Controlled

Last BS: _____ Date: _____

Neuropathy Kidney Damage Retinopathy/Retina Surgery OTHER: _____

Family History: (Indicate family member of all that apply)	Your Eye History: (Circle all that apply)	Any EYE surgery: (List below)	Have you EVER taken the following: (Circle all that apply)	Social History: (Circle all that apply)
Cancer	Eye Injury	_____	Accutane	SMOKE
Diabetes	Cataracts	_____	Prednisone (steroids)	Current
Cataracts	Fuchs	_____	Plaquenil	Former Smoker
Glaucoma	Keratoconus	Drug Allergies?	Isoniazid	Never Smoked
Macular Degen (ARMD)	Glaucoma	Sulfa	Ethambutol	ALCOHOL
Cornea Disease	Lazy Eye	Penicillin	Blood Thinners	Drink Daily - Social
Retina Problems	Retinal Problems	Phenylephrine	Flomax	Former Alcoholic
Unknown	Macular Degen	Tetracaine NONE	Tamoxifen	Never drink
NONE	Dry Eyes	OTHER ALLERGIES:	Elmiron	RECREATIONAL DRUGS
	NONE	_____	NONE	Current drug use
				Former drug use
				NEVER

Major SURGERIES OR RECENT Hospitalizations: _____

MEDICATIONS- ELECTRONIC PRESCRIBING: **IF YOU HAVE A LIST OF YOUR MEDICATIONS,** give this to the front desk to copy. Our system connects to *E-prescribing* which allows us to communicate with your pharmacy to **send prescriptions, receive refill requests, and pull a list of your current medications.** Inform the clinic if you take any medications or supplements that are not filled through your pharmacist (prescription or over the counter).

Do you currently wear glasses? **YES NO**

Circle all that apply: Full-time Part-time Rarely
Bifocals Progressives Driving only Reading only

Do you wear contact lenses? **YES NO**

Circle all that apply: Full-time Part-time Monovision
Multifocals Extended (sleep in)

At Sylvester Eye Care, our surgeons provide specialty medical eye care as well as cosmetic and refractive surgeries.

ARE YOU INTERESTED in more information about these services?

➔ FREE **LASIK** CONSULT **YES NO**

➔ **COSMETIC** EYE SURGERY, **BOTOX**, or **FILLERS** **YES NO**

PATIENT NAME: _____ **DATE:** ____ / ____ / ____

Consent to Discuss Your Protected Health Info (PHI)

We need permission to speak to anyone about your eye care *other* than a referring or co-managing provider.

PHI= Personal Health Information that identifies you with your medical history, treatments, medications, STDs/HIV/AIDS, mental health, drug use, visual disability...

SYLVESTER EYE CARE (SEC) will never share your **PHI** without your permission and will refer to this form if anyone wants to discuss your appointments or treatment plan. You can update/sign a new form anytime.

*I give permission for SEC to **VERBALLY DISCUSS MY CARE and PHI with my other physicians AND with:***

NO ONE (only myself) **Person(s)** listed below:
Initial if NO ONE Initial if you consent to share below

Name, PHONE, RELATION (only if you allow us to discuss your care)

Consent to Dilate Your Eyes

Eyedrops are used for a dilated medical eye exam in addition to imaging technology to view your retina.

SIDE EFFECTS: *blurred vision* (mostly near vision), *light sensitivity*. Less common: headache, nausea, dizziness.

DURATION: 4-6 hours (in most cases)

DRIVER: Secure a driver if you are unsure how the drops affect you. Temporary **Sunglasses** are available.

UNCOMMON REACTIONS: Hives, itchy or puffy eyelids, difficulty breathing- If you are allergic to **PHENYLEPHRINE (Sudafed)**- *inform us BEFORE drops are instilled.*

RARE REACTIONS: "*Acute Angle-Closure Glaucoma*" - **severe** headache, nausea/vomiting. Contact us ASAP if severe symptoms develop.

Initial to consent I **CONSENT** to be dilated, I have read above and agree to arrange for a driver if necessary.

Initial to decline I **DECLINE** dilation, I understand that this will not be a comprehensive eye exam.

HIPAA Consent & Notice of Privacy Practices (NPP)

Please review our full NPP which describes how SEC may use or disclose your PHI while providing your care and billing for services. Any changes to our NPP will be made available.

- ✓ You have the right to review this Notice before signing.
- ✓ You have the right to request the usage/disclosure of your PHI be restricted while SEC is providing treatment, health care operations, and billing for services.
- ✓ You have the right to withdraw this consent at any time in writing (effective from that date forward).

If you refuse to consent or request limited use of PHI, SEC may refuse to provide treatment, other than required emergency services. This consent remains in effect unless and until you withdraw it in writing.

Initial I have reviewed the NPP and understand my HIPAA rights. I have been offered a copy of Sylvester Eye Care's NPP.

Cancellation and No-Show Policy

GOAL: Our staff is always focused on quality eye care while improving efficiency to minimize patient wait times.

Your appointment will be considered a **"NO SHOW"** if:

1. You miss your appt without **TEXTING OR CALLING**
2. You **CANCEL with LESS than 24 hours' notice**
3. You arrive more than **15 minutes late** or do not have required paperwork completed- out of respect for other patients, we may need to reschedule if you arrive late.

Patients who "NO SHOW" *three (3) times in 12 months:*

- **\$50 fee (\$100 for procedures)**-this non-refundable fee must be paid **IN FULL BEFORE** scheduling again. (Medicaid exception applies).

Initial I have read above and will arrive on time with paperwork completed or give at least 24 hours' notice to reschedule.

Initial **ELECTRONIC COMMUNICATION:** We use a HIPAA compliant system to send appointment confirmations/reminders or to communicate via text or email. SEC cannot protect your PHI once the message is received on your end. You can OPT OUT of receiving messages however, this will make it harder for SEC to reach you.

Initial **CONSENT TO TREAT:** I agree to receive medical eye care and treatment by the physicians and staff of SEC. I consent to the examinations and tests ordered by my physician. I understand there are no guarantees in medical care, and it is my responsibility to comply with my treatment plan and to report any new symptoms or complications.

Initial **FINANCIAL AGREEMENT:** I agree to pay for all services rendered that are not covered by insurance. *If am insured, I authorize my insurance payment to be made directly to Sylvester Eye Care and authorize release of any part of my medical records (including PHI that may be sensitive) to contracted agents of my insurance company and SEC as needed to process claims. If this form is not signed, I will be responsible for all charges before services are rendered.*

Printed name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date