MEDICAL PATIENTS

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

Welcome

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 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: ** Please complete **

_____

→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:

_____

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

_____ _____
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

ROUTINE VISION INSURANCE: _____ *

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

_____ _____
Name & DOB of Subscriber for Vision Insurance *Last 4 of SSN*

We cannot file Vision Insurance during a medical visit

DO YOU WANT A NEW GLASSES PRESCRIPTION?

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

sylvester
EYE CARE & AESTHETICS

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:** _____

Last BS: _____ **Date:** _____

***IF YES, CIRCLE ALL THAT APPLY*:** Type 1 Type 2 On Insulin Diet Controlled
Neuropathy Kidney Damage Retinopathy/Retina Surgery OTHER: _____

Family History:
(Indicate family member of all that apply)
Cancer
Diabetes
Cataracts
Glaucoma
Macular Degen (ARMD)
Cornea Disease
Retina Problems
Unknown
NONE

Your Eye History:
(Circle all that apply)
Eye Injury
Cataracts
Fuchs
Keratoconus
Glaucoma
Lazy Eye
Retinal Problems
Macular Degen
Dry Eyes
NONE

Any EYE surgery:
(List below)
_____
_____

Drug Allergies?
Sulfa Penicillin
Phenylephrine
Tetracaine NONE

Other Allergies:
_____

Have you *EVER* taken the following:
(Circle all that apply)
Accutane
Prednisone
(steroids)
Plaquenil
Isoniazid
Ethambutol
Blood Thinners
Flomax
Tamoxifen
Elmiron
NONE

Social History:
(Circle all that apply)
SMOKE
Current
Former Smoker
Never Smoked
ALCOHOL
Drink Daily - Social
Former Alcoholic
Never drink
RECREATIONAL DRUGS
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**
◯ Full-time ◯ Part-time / As needed

Do you wear contact lenses? **YES** **NO**
◯ Every day ◯ Part-time ◯ Overnight wear

Are you ***interested*** in Contact lenses? **YES** **NO**

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 Heath Info (PHI)

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

PHI= personal 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.

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

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

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.

_____ *I have reviewed the NPP and understand my HIPAA rights.*
Initial *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).

_____ *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.
Initial

Printed name of Patient or Legal Guardian **Signature of Patient or Legal Guardian** **Date**

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