Lowcountry Eye Specialists

**Patient Name**:_____ **Date:**_____
Last First Middle Initial

**Address**:_____**City**:_____

**State**:_____ **Zip**:_____ **DOB:**_____ **SS#**_____

**Home#**_____ **Cell#**_____ **Work#**_____

**Email:**_____ *Practices are required to obtain this to offer patients a web portal.

**Emergency Contact**:_____**Relationship**:_____**Phone#:**_____

## DEMOGRAPHICS

(The American Recovery and Reinvestment Act of 2009 requires practices to use Electronic Health Records and collect this data for statistical purposes only.)

| | |
|---|---|
| **Gender:** Male Female | **Race:** American Indian or Alaska Native Black White Native Hawaiian or Pacific Islander Asian Other |
| **Preferred Language**: English Other | **Ethnicity**: Hispanic or Latino Non-Hispanic or Latino |
| **Occupation:** Retired Student Disabled Homemaker Unemployed | |

## SOCIAL HISTORY

| | | |
|---|---|---|
| **Tobacco use:** Never smoked Former smoker Current some day smoker Current every day smoker | | |
| **Alcohol use:** None Socially Moderate Heavy Alcoholic Recovering Alcoholic | | |
| **Street Drug use:** If yes, please list. None | **Are you pregnant?** Yes No N/A (Male) | |
| **Have you ever received a pneumonia vaccine?** Yes No | **Primary Care Physician:** | **Eye Care Physician:** |
| **Who referred you:** | | |
| **Pharmacy name/address:** | **Date of last eye exam:** | |

## INSURANCE

| | | | |
|---|---|---|---|
| **Primary Insurance:** | **ID#:** | **Subscriber Name**: | **Relationship to Patient**: Self Spouse Parent |
| (If other than patient, please fill in the following) **Subscriber DOB:** | | **SS#**: | |
| **Secondary Insurance:** | **ID#:** | **Subscriber Name**: | **Relationship to Patient**: Self Spouse Parent |
| (If other than patient, please fill in the following) **Subscriber DOB:** | | **SS#**: | |

I, the undersigned patient or guarantor, certify that I have active coverage with the above insurance companies and assign directly to Dr. Jay Thompson all insurance benefits, if any, otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT, PAID BY INSURANCE**. I understand it is my responsibility to ensure network participation and obtain any authorizations that may be required by my insurance in order to receive maximum benefits. I understand that all **COPAYS** are due and payable at the time of service, and agree to pay any applicable **CO-INSURANCE** and **DEDUCTIBLE** amounts not collected at the time of service, within 30 days, unless I have made prior arrangements for a payment plan with Dr Thompson's office staff. Please contact your insurance company to fully understand your benefits and your financial responsibilities for the services you may require. Our office staff is ready to assist you in any way we can.

**I have received a copy of Lowcountry Eye Specialists Notice of Privacy Practices. Please initial (____)**

**Patient or Guarantors Signature**:_____**Date:**_____

**Print name of above if other than patient**:_____**Relationship:**_____

(Form created May 2015)

# Lowcountry Eye Specialists
## Communication Authorization

Patient Name:_____DOB:_____

- Initial here_____if you do not want your healthcare information discussed with anyone other than yourself.
- If you would like us to discuss your healthcare information (e.g. test results, prescription information etc.) with anyone other than yourself (spouse, family members), please list below any individuals whom you authorize.

**Purpose of request**- I authorize **LOWCOUNTRY EYE SPECIALISTS** to disclose or provide protected health information, about me to the individual(s) listed below.

**Who will be authorized to receive information?** (list the individual/entity who is to receive your information)

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

**Description of information to be disclosed-** I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **All** of my past, present and future health information

**OR**

☐ All of my past, present, and future health information with the exception of the following information:

☐ Mental health records ☐ Alcohol/drug abuse treatment

☐ Communicable diseases (including HIV and AIDS) ☐ Other (please specify):_____

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify)_____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person (s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

**Please sign the next available signature line below**

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

You have the right to receive a copy of signed authorizations upon request

(Form created May 2015)

Lowcountry Eye Specialists

**PATIENTS NAME:**_____ **DOB:**_____ **DATE:**_____

**EYE HISTORY:** Have you experienced or been diagnosed with any of the following:

Cataracts Dry Eyes Diabetic Retinopathy Glaucoma Macular Degeneration

Retinal Detachment Eye injury or trauma (If yes, please explain)_____

**Have you had previous eye surgery?** Yes No (If yes, please fill in the details below)

Eye: Right Left Procedure:_____ Surgeon:_____ Date:_____

Eye: Right Left Procedure:_____ Surgeon:_____ Date:_____

**Have you ever, or do you currently wear contacts?** Yes No (If yes, please fill in the details below)

Date last worn:_____ Brand:_____ Power: Right eye_____ Left Eye_____

**PLEASE DESCRIBE THE REASON FOR YOUR VISIT:**_____

_____

**Do you currently use eye drops?** Yes No (If yes, please fill in the details below)

Name of drop:_____ Frequency used:_____ Eye(s): Right Left Both

Name of drop:_____ Frequency used:_____ Eye(s): Right Left Both

**DRUG ALLERGIES:** **None** Aspirin Codeine Sulfa Penicillin Other_____

**MEDICAL HISTORY:**

| | | |
|---|---|---|
| AIDS/HIV + | COPD | Hepatitis (type____) |
| Acid Reflux | Congestive Heart Failure | Kidney Disease |
| Allergies (seasonal) | Coronary Artery Disease | Lupus |
| Alzheimer's | Dementia | Migraines |
| Anxiety | Depression | Pacemaker |
| Arthritis | Diabetes (controlled by Diet Pills Insulin) | Rheumatoid Arthritis |
| Artificial Heart Valve | Drug Sensitivity | Rheumatic Fever |
| Artificial Joints | Emphysema | Shingles |
| Asthma | Epilepsy | Skin Condition |
| Bleeding Disorder | Heart Condition (type_____) | Stroke |
| Cancer (type_____) | High Blood Pressure | Thyroid Condition |
| Chemical Dependency | High Cholesterol | Tuberculosis |
| Other_____ | _____ | _____ |

**CURRENT MEDICATIONS:** **None**

| MEDICATION | DOSAGE | FREQUENCY | MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|---|---|---|
| 1. | | | 6. | | |
| 2. | | | 7. | | |
| 3. | | | 8. | | |
| 4. | | | 9. | | |
| 5. | | | 10. | | |

**PREVIOUS SURGERIES:** **None** _____ _____ _____

**FAMILY HISTORY:** Have any of your immediate family (Father, Mother, Grandparent, Sibling) been diagnosed with the following?

Cataract (Relation to you:_____) Diabetes (Relation to you:_____)

Glaucoma (Relation to you:_____) Macular Degeneration (Relation to you:_____)

Other_____ (Relation to you:_____) **Unknown** **Adopted**

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# DILATION

Dilating drops are used to dilate or enlarge the pupil of the eye. This is necessary for the doctor to perform a complete exam of the retina and the back of the eye.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you feel that you cannot safely drive after being dilated, we recommend that you make alternative transportation arrangements. However, a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide for you after your dilation. Please be cautious and determine what is best for you.

# REFRACTION

A refraction is a diagnostic test used to determine the best possible visual acuity and function of your eye.

It is a critical part of any complete eye exam and MUST be done if you are here for a cataract evaluation, have any vision complaints, there is a change in your vision, and/or you would like a prescription for glasses.

As indicated by the federal government, the refraction is a non-covered service by most medical insurance plans including Medicare and Medicaid as they consider this a “vision” service, not a “medical” service.

The fee for a refraction is $40.00 and is collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. If you do not want this test done, please let the technician doing your exam know.

**Acknowledgment**: By signing below I acknowledge that I have read and understand the above information.

**Patient Signature:**_____ **Date:**_____

*If you are here for a cataract evaluation and have had a refraction within 90 days, we will attempt to get a copy of it from your Optometrist so you don’t have to have it repeated.