Have you had any surgeries on your eyes?

Type of surgery	Eye	When?

Have you been diagnosed with any eye disease or conditions? (please circle)

Cataracts	Macular Degeneration	Retinal Detachment
Glaucoma	Eye Injury	Diabetic Retinopathy
Dry Eye	Conjunctivitis	Lazy Eye

Are you taking any medications for your eyes?

Medication	Eye	How many times daily?

Are you taking other medications? (please bring a separate page if needed)

Medication	Dosage	How many times daily?

Are you allergic to any medications? (please check beside each one)

	Yes	No		Yes	No
Latex			Keflex or Cephalosporin's		
Tape			Betadine/Iodine		
Penicillin			Anesthesia Medications		
Vancomycin			Seafood		
Cipro (Fluoroquinolones)			Egg White		
Gentamicin/Tobramycin			Soybeans		
Sulfa			**List:**		

Have you been diagnosed with any of the following? (please circle)

Acid Reflux	Arthritis	Asthma
CVA (stroke)	COPD	Coronary Artery Disease
Breast Cancer	Cervical Cancer	Lung Cancer
Prostate Cancer	Skin Cancer	Leukemia
Dementia	Depression	Diabetes
Heart Attack	High Cholesterol	High Blood Pressure
Lupus	Migraine	Obesity
Osteoporosis	Prostate Problems	Sleep Apnea
Stroke	Thyroid Disease	Tuberculosis

Other: _____

Primary Physician: _____ Location: _____

Name: _____ Date of birth: _____/_____/_____

Have you had any surgeries on your body? (please bring a separate page if needed)

Type of surgery	When

Family Medical History: please indicate if your family members have had any of the following:

Condition	Yes	No	Who?	Condition	Yes	No	Who?
Glaucoma				Crossed Eyes			
Cataracts				Blindness			
Cancer				Retinal Detachment			
Diabetes				High Blood Pressure			
Stroke				Macular Degeneration			
Heart Disease				Tuberculosis			

Social History: (please circle)

Tobacco Use:	Every Day Use	Occasional Use	Former User	Never
Alcohol Use:	Every Day Use	Occasional Use	Former User	Never
Drug Use:	Every Day Use	Occasional Use	Former User	Never
Lives With:	Spouse	Alone	Family	Other:
Occupation:				
Activities:	☐Computer ☐Television ☐Driving ☐Crafts/Sewing ☐Music/Instruments ☐Hunting ☐Fishing ☐Skiing ☐Boating ☐Jogging ☐Exercising			

Review of Systems: (Circle any problems you have)

Cardiovascular	Constitutional	Blood Pressure	Genitourinary
Chest pain	Fatigue	Borderline control	Genital discharge
Irregular heartbeat	Fever	Good control	Genital lesions
Short of breath	Night sweats	Itching	Painful urination
	Weakness	Poor control	Urgency
	Weight loss	Unknown control	Frequent urination

Heent	Hematologic	Diabetes Control	Musculoskeletal
Dizziness	Bleeding	Borderline control	Back pain
Hearing loss	Bruising	Good DM control	Joint pain
Hoarseness	Tender nodes	Poor DM control	Muscle aches
Ringing in ears		Unknown control	Stiffness
Sore throat			Swelling

Neurological	Psychiatric	Respiratory	Skin
Balance problems	Anxiety	Cough	Hair loss
Headaches	Depression	Trouble breathing	Rash
Numbness	Nervousness	Wheezing	Skin lesions
Tingling	Irritability		

Have you ever taken **Flomax/Tamsulosin, Uroxatrol, Hytrin, or Cardura**? (if yes, please circle)

Have you ever had **Hepatitis, MRSA/Staph, or AIDS/HIV**? (if yes, please circle)

Name: _____ Date of birth: _____/____/_____

CHERYL L. BENNETT, OD

RELEASE OF INFORMATION/ PATIENT CONSENT FOR USE

AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE OF INFORMATION:
I authorize Cheryl L. Bennett, OD (the "Practice") to release, by electronic means or otherwise, any medical and/or billing information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions

I hereby consent to the Practice using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that: I have had the right to review the Practices' Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its' Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request to the Practice.

CONSENT TO CALLS/MAIL/EMAIL: I hereby consent to the Practice calling my home, cell phone or designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment. I also consent to the use of predictive dialers and prerecorded messages. I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO. I understand that the Practice may share my PHI with my family unless I sign the objections to do so. Sign the line right below, only if you object to PHI and TPO being shared with your Family.

_____

I understand that I have the right to request that the Practice restrict how it uses or disclosure of my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By SIGNING THIS FORM, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information, I am consenting to have my PHI and TPO shared with my Family, unless I have signed the line above objecting to the sharing of my PHI and TPO with my Family. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date

_____

Patient's Name Phone (cell/home)

DILATION CONSENT, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

DILATION CONSENT:

Dilation will enlarge your pupils to allow a better view of the inside of your eye. Many medical conditions require dilation in order to find and/or evaluate these conditions. An eye exam is not considered thorough without dilation. Due to the widening of the pupil, dilation will blur vision for a length of time, which varies from person to person. It will affect the comfort and ability of many patients when reading and create light sensitivity. It is not possible to predict how much your vision will be affected. You should use caution when driving or engaging in other hazardous activities while your pupils are dilated. An adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. Disposable sun shades will be given to you after dilation to protect your eyes in bright illumination. If you would happen not to receive sun shades before you leave our office, please ask for a pair.

Patient or Responsible Party Signature _____ Date ____/____/____

PARTICIPATING/ NON-PARTICIPATING INSURANCE:

Cheryl L Bennett OD/ The Spectacle Family Eye Care is a participating provider for a variety of managed care plans, and we bill directly as a courtesy to you. We accept payment for covered services from these insurance plans in accordance with our contracts. You are responsible for applicable co-insurance and deductible amounts, as well as payment for services that are not covered by insurance, such as routine eye exams, refractions and cosmetic procedures. *If there is no medical problem such as glaucoma or cataracts, then the exam is considered "routine" and is not a covered benefit. Please consult with your insurance carrier*. If your healthcare insurance requires a referral from your primary care physician, you are required to obtain this referral prior to arriving for a specialty physician office visit.

If we are not a provider for your insurance carrier, and you wish to be seen, you are responsible for payment of all charges at the time of service. You are then responsible for submitting the claim to your insurance company for reimbursement.

I authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____/____/____

MEDICARE PATIENTS ONLY:

We are a participating provider of the Medicare Program. We will accept assignment on all claims and bill Medicare directly for you. Patients are responsible for meeting their annual deductible and paying their 20% copayment. We do file with second/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration Health Care Financing Administration or its intermediaries or carrier any information needed for this is or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or the party who accepts assignment.

Patient or Responsible Party Signature _____ Date ____/____/____

If you have a supplemental policy, and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over," we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Patient or Responsible Party Signature _____ Date ____/____/____

THE SPECTACLE FAMILY EYECARE

REGISTRATION FORM

Today's date:	Date of birth:	Male / Female

PATIENT INFORMATION

Patient's Last name: First: Middle:	Preferred Name:	Marital status (circle one) Single / Mar / Div / Wid
Social Security no:	Home phone: ( )	Cell phone: ( )
Mailing address:	City:	State: ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )
E-mail address:		

PARENT OR RESPONSIBLE PARTY

Name:	Birth date: / /	Address (if different):	Phone (if different).: ( )
Social Sec no:	Employer:	Employer address:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Previous Patient ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by medical insurance? ❑ Yes ❑ No

Is this patient covered by routine vision insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ BCBS ❑ Cigna ❑ Humana ❑ Medicaid ❑ Medicare ❑ PEIA ❑ Tri-Care ❑ United Healthcare ❑ Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Spectacle Family Eyecare or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***