



Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Nickname or prefers to be called: \_\_\_\_\_

SSN: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Address:

\_\_\_\_\_  
(Street Address or P.O. BOX) (City) (State) (Zip Code)

Email Address for notifications: \_\_\_\_\_

Cell Phone Number for notifications: \_\_\_\_\_

Alternate Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Preferred method of contact?  Email  Text  Phone Call

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If patient is under 18 years of age:

Guardian/Guarantor Name: \_\_\_\_\_

Guardian/Guarantor DOB: \_\_\_\_\_

Referred by:

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> PCP or Specialist | <input type="checkbox"/> Friend/Family Member | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pediatrician      | <input type="checkbox"/> Internet             |                                      |
| <input type="checkbox"/> Walk in           | <input type="checkbox"/> Eyemart Express      |                                      |

Name of Patient \_\_\_\_\_ Today's Date \_\_\_\_\_

**Please check any problems you have currently or have been diagnosed with in the past:**

- |   |                               |                        |
|---|-------------------------------|------------------------|
| ___ Age-related macular degeneration    | ___ Iritis/Uveitis            | ___ Amblyopia/Patching |
| ___ Glaucoma                            | ___ Dry Eyes                  | ___ Keratoconus        |
| ___ Eye Surgery; Type _____             | ___ Diabetic Retinopathy      | ___ Nystagmus          |
| ___ Retina defects (tears, detachments) | ___ Floaters/Flashes of light | ___ Eye Infection      |
| ___ Injury to Eyes _____                |                               |                        |

**Do you have any other concerns with your eyes or vision?**

**Do you currently wear?**  Glasses or  Contact Lenses: Please list brand \_\_\_\_\_

How often do you sleep in your contact lenses? \_\_\_\_\_ How often do you replace them? \_\_\_\_\_

**Please check any medical conditions that apply to you:**

**Constitutional:**

- \_\_\_ Developmental delays/disabilities
- \_\_\_ Cancer
- \_\_\_ Fever

**Ears/Nose/Throat:**

- \_\_\_ Hearing Loss
- \_\_\_ Allergies/Sinusitis

**Neurological:**

- \_\_\_ Multiple Sclerosis
- \_\_\_ Seizures
- \_\_\_ Cerebral Palsy
- \_\_\_ Tumor
- \_\_\_ Stroke
- \_\_\_ Headaches/Migraines

**Psychiatric:**

- \_\_\_ Depression/Anxiety
- \_\_\_ Attention deficit disorder

**Cardiovascular:**

- \_\_\_ High Blood pressure
- \_\_\_ Heart disease

**Respiratory:**

- \_\_\_ Asthma
- \_\_\_ Emphysema/COPD
- \_\_\_ Sleep Apnea

**Gastrointestinal:**

- \_\_\_ Crohn's
- \_\_\_ Acid reflux

**Genitourinary:**

- \_\_\_ Kidney disease
- \_\_\_ Prostate
- \_\_\_ STD
- \_\_\_ Pregnant/Nursing

**Musculoskeletal:**

- \_\_\_ Arthritis
- \_\_\_ Fibromyalgia

**Integumentary:**

- \_\_\_ Rosacea
- \_\_\_ Psoriasis
- \_\_\_ Cold Sores/Shingles

**Endocrine:**

\_\_\_ **Diabetes: Type 1 or Type 2**

A1C \_\_\_\_\_ Dr. \_\_\_\_\_

\_\_\_ Thyroid

**Hematologic/Lymphatic:**

- \_\_\_ High cholesterol
- \_\_\_ Anemia

**Allergy/Immunology:**

- \_\_\_ Environmental Allergy
- \_\_\_ Rheumatoid arthritis
- \_\_\_ Lupus
- \_\_\_ Sjogren's Syndrome
- \_\_\_ Drug: \_\_\_\_\_

**Please list any other medical conditions:** \_\_\_\_\_

**Please list any current medications:** \_\_\_\_\_

**Social History**

Do you smoke or use tobacco?  No  Yes How much/often? \_\_\_\_\_

Do you drink alcohol?  No  Yes How much/often? \_\_\_\_\_

**Family History**

Does anyone in your **immediate** family (**parents, grandparents, siblings, children**) have any of the following medical conditions? (**please mark all that apply and list who next to the condition**)

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| ___ Cataracts            | ___ Lazy Eye             | ___ High Blood Pressure |
| ___ Macular Degeneration | ___ Diabetic Retinopathy | ___ Thyroid disease     |
| ___ Glaucoma             | ___ Cancer               | ___ Heart disease       |
| ___ Retinal detachment   | ___ Diabetes             |                         |



## Consent and Authorization Form

**\*\*SIGNATURE REQUIRED FOR ALL PATIENTS\*\***

### **CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)**

\*I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

**XPatient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient's Name if guardian named above : \_\_\_\_\_ Date: \_\_\_\_\_

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**\*\*SIGNATURES REQUIRED ONLY FOR PATIENTS USING INSURANCE\*\***

### **PAYMENT POLICY/ASSIGNMENT OF BENEFITS to FILE INSURANCE/RELEASE OF INFORMATION:**

\*I hereby authorize payment directly to Hutton Family Eye Care. All Self-Pay or Insurance Co-Pay, including non-covered services, are due at the time of service. I understand that I am responsible for all charges not covered by my insurance. A Self Pay discount is not allowed for services billed to my insurance carrier. I hereby authorize release of all information necessary to pay my claim. There will be additional fees for any past due balances that are transferred to a collection agency. All professional services are nonrefundable.

**XPatient/GuardianSignature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **ROUTINE VISION PLAN vs. MEDICAL INSURANCE**

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and HFEC accepts many vision care plans and insurance plans in both categories: (1) **Routine** Vision plans (such as VSP, VCP, EyeMed & Spectera and (2) **Medical** insurance (such as Blue Cross/Blue Shield, United Health Care, Medicare and others).

- Vision Plans cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Routine Vision plans do NOT provide for MEDICAL EYE HEALTH CARE NEEDS.
- Medical Insurance MUST be submitted for any medical diagnosis and treatment care and follow-up.
- If you have both Routine Vision Care benefits and Medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.
- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract. Please provide both your routine vision plan provider and medical insurance card(s) and identification, for your benefit, to our staff so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance. **I UNDERSTAND THE ROUTINE vs. MEDICAL INSURANCE POLICY:**

**XPatient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## OPTOMAP & MATRIX Consent Form

**Optomap® Retinal Photos** provides a detailed digital picture of the retina to reveal the health of your eyes. This quick non-invasive screening test helps detect diseases such as **diabetes, high blood pressure, macular degeneration, retinal tears and some tumors.**

- *Allows you to see what your eye looks like- just as the doctor sees it*
- *Allows the doctor to dilate less frequently in most cases*
- *Performed quickly without side-effects of light sensitivity and blurred vision*
- *Creates a permanent record as a baseline for future comparisons*

**Matrix Visual Field Analyzer** provides a computerized examination of your peripheral vision. The visual field screener detects early visual peripheral field loss like a **CAT SCAN** specifically for the eye. It is the earliest method of detection of many diseases such as **brain tumors, glaucoma, retinal and macular degeneration, optic nerve disease, and retinal disturbance due to vascular problems or medications.**

We strongly recommend that all of our patients over the age of 20 receive both of these tests once a year. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, an abnormally high prescription, retinal problems, or if you have family members who suffer from any of the above.

### Please mark your preferences below:

\_\_\_\_\_ I prefer to have Optomap Retina Photos today instead of dilation for additional fee of \$25

\_\_\_\_\_ I prefer to have Matrix Visual Field Screening today for additional fee of \$25

\_\_\_\_\_ I prefer to have my eyes dilated today. I understand the risks/potential side effects of the dilation, including blurry vision and light sensitivity. I have a driver with me or will arrange for one at the conclusion of the exam if I feel I am unable to drive safely.

\_\_\_\_\_ I prefer to defer the dilation, Optos screening photos, and Visual Field Screening. I understand that there may be diseases, conditions, and/or problems that the doctor cannot rule out as a result of declining these recommended tests. Therefore, I do not hold Dr. Hutton or the associates of Hutton Family Eye Care liable for any delay in diagnosis and treatment that may result from my deferring the above recommended tests today.

**X**Patient /Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_