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

If patient is under 18 years of age:

Guardian/Guarantor Name:___________________________

Guardian/Guarantor DOB:_____________________________

Referred by:

___**PCP or Specialist**
___**Pediatrician**
___**Walk in**
___**Friend/Family Member**
___**Internet**
___**Eyemart Express**
___**Other**___________

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
___Glaucoma
___Eye Surgery; Type_________
___Retina defects (tears, detachments)
___Injury to Eyes_________________
____Iritis/Uveitis
____Dry Eyes
____Diabetic Retinopathy
____Floaters/Flashes of light
___Amblyopia/Patching
___Keratoconus
___Nystagmus
___Eye Infection

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
___Macular Degeneration
___Glaucoma
___Retinal detachment
___Lazy Eye
___Diabetic Retinopathy
___Cancer
___Diabetes
___High Blood Pressure
___Thyroid disease
___Heart disease

Consent and Authorization Form**SIGNATURES 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: ______________

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-Pays, including non-covered services, are due at the time of service and I have read and understood the posted payment policy.** 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/Guardian Signature:_____________________________________Date:_________________

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ROUTINE VISION PLAN vs. MEDICAL INSURANCESIGNATURE REQUIRED ONLY FOR PATIENTS USING 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.
- 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:**

DO YOU HAVE A HIGH DEDUCTIBLE MEDICAL PLAN? YES NO

IF SO, HAS YOUR DEDUCTIBLE BEEN MET? YES NO

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:

__________ **Optomap Retina Photos instead of dilation for additional fee of $35**

__________**Matrix Visual Field Screening for additional fee of $40**

_________ **Both tests above for additional fee of $60 ($15 discount)**

__________ **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:**__________________