Forest Creek Eye Center 1701 Red Bud Lane, Round Rock TX 78664 512-341-2020

Patient Information

Patient Information			
Name (First, Middle, Last)		Nickname/Preferred Name *(preferred pronouns if applicable)*	
Birth Date	Age	Social Security #	Birth Gender □ Male □ Female
Mailing Address		City, State, ZIP	
Cell Phone Number		Home Phone Number	
Email Address			
Preferred method of contact *(check all that apply)* □ Cell Phone □ Home Phone □ Email		May we leave a detailed message pertaining to your appointment, vision and/or medical needs? □ Yes □ No	
Occupation		Employer *(or parent/guardian employer if patient is a minor)*	

Emergency Contact		
Contact Name	Phone Number	Relationship to patient

Insurance Information (please present your insurance card to our front desk staff)		
Primary/Vision Insurance	Member ID	Group #
Policy Holder	Policy Holder DOB	Relationship to Policy Holder □ Self □ Spouse □ Dependent
Secondary Insurance	Member ID	Group #
Policy Holder	Policy Holder DOB	Relationship to Policy Holder □ Self □ Spouse □ Dependent

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? □ Yes □ No

Who may receive information on your behalf regarding testing or referrals?

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Office Policies

Cancellation & No Show Policy

When you schedule an appointment with Forest Creek Eye Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Patients who fail to show for their scheduled appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

X _____ (Initial) I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

HIPAA Acknowledgment of Receipt of Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provides who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers (e.g. my insurance company)
- Conduct day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature _____ Date: _____

Acceptance of Insurance & Financial Responsibilities

X _____ (Initial) As a service, Forest Creek Eye Center verifies and files insurance claims on behalf of patients. However, I understand that what may be quoted as my portion of financial responsibility (co-payment and/or co-insurance) is ONLY an estimate provided by my insurance carrier. I AGREE to be responsible for what insurance does not cover for the services rendered. I realize that insurance benefits must be presented and verified at the time of service. Forest Creek Eye Center CANNOT refund me for insurance benefits that were not verified at the time of service date.

Refraction Policy

A refraction is the testing procedure which determines your need for glasses to correct your vision, also referred to as your eyeglass prescription.

Some insurance <u>MAY NOT</u> cover your refraction. If this is the case, you will be responsible for the **$39.00 refraction fee**.

X _____ (Initial) I have read the Refraction Policy and understand that I am responsible for the refraction fee if my insurance does not cover this service

Reason for Today's Visit

Check all that apply: □ Annual check-up □ Update Glasses Prescription □ Update Contact Lens Prescription
□ Medical Examination/Eye Problem
□ Other

Ocular History

Date of last eye exam: _____ Name of Previous Eyecare Provider: _____

Do you currently wear glasses? □ Yes □ No

Do you currently wear contact lenses? □ Yes □ No
If yes, are your contact lenses comfortable? □ Yes □ No
Brand of contact lenses you currently wear _____
How often do you dispose of them? □ Daily □ 2 Weeks □ Monthly □ Other _____
How many hours a day do you usually wear your contacts? _____

Are you **CURRENTLY** experiencing any of the following?

	Yes	No	Which Eye?		Yes	No	Which Eye?
Loss of Vision	□	□	_____	Chronic Infection of Eye or Lid	□	□	_____
Distorted Vision	□	□	_____	Chalazion/Hordeolum ("Stye")	□	□	_____
Double Vision	□	□	_____	Flashes/Floaters in Vision	□	□	_____
Glare	□	□	_____	Excess Tearing/Watering	□	□	_____
Light Sensitivity	□	□	_____	Dryness	□	□	_____

Have you ever been **DIAGNOSED** with any of the following?

	Yes	No	Which Eye?		Yes	No	Which Eye?
Cataract	□	□	_____	Retinal Hole/Tear	□	□	_____
Glaucoma	□	□	_____	Retinal Detachment	□	□	_____
Macular Degeneration	□	□	_____	Amblyopia ("lazy eye")	□	□	_____
Diabetic Retinopathy	□	□	_____	Strabismus ("eye turn")	□	□	_____
Eye Injury	□	□	_____	Keratoconus	□	□	_____
Retinal Disease	□	□	_____	Other: _____	□	□	_____

Please check any eye surgeries you have had:
□ LASIK □ PRK □ RK □ Cataract Surgery □ Laser Repair □ Other _____

Dilation

Dilation is an important part of assessing the health of the eyes. The dilation drops widen the pupil, enabling your optometrist to view to inside of the eye. This assists your doctor in diagnosing eye disease, possibly at their earliest stages, such as diabetes, high blood pressure, glaucoma, macular degeneration, retinal holes, retinal tears, or retinal detachments. Dilation will make your eyes more light sensitive and make your vision blurry up close for about 3-4 hours. If you are concerned about the effects, please discuss with your doctor.

□ YES, it is okay to dilate my (or my child's) eyes today
□ NO, I understand the importance of dilation and accept the risk of declining today
□ I would like to further discuss with the doctor

Retinal Screening

We are excited to offer a new technology to our patients, the CLARUS Ultra-Widefield Fundus Imaging System. It is a touch-free, painless scan that takes only seconds to complete and takes an image of the back of the eyes. The images these scans produce can help our doctors identify signs of vision-threatening diseases such as glaucoma, macular degeneration, and diabetic retinopathy. Therefore, **we recommend a baseline retinal screening image for all of our patients as part of their annual health examination.**

- The CLARUS screening does not replace traditional dilation.
- The CLARUS screening is not covered by insurance, and is a **$39 fee payable today.**
- Your doctor will review the images with you as part of your exam.

□ YES, I would like to have the CLARUS retinal screening today
□ NO, I am declining the CLARUS retinal screening

Signature _____ Date: _____

Primary Care Doctor/Other Healthcare Providers

	Doctor/Provider	Practice Name	Last Visit
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Medications & Allergies

Preferred Pharmacy: _____

Drug Allergies: □ No known drug allergies □ Drug allergies: _____

Medication & Dosage	Treats what Condition

Medication & Dosage	Treats what Condition

**please include any eye drops you are currently using*

Social History

	Yes	No	If yes, please specify which type/amount/how long
Do you currently drive?	□	□	N/A
Do you drink alcohol?	□	□	_____
Do you use tobacco products?	□	□	_____
Do you use illegal drugs?	□	□	_____

Does the patient have any learning or behavioral disabilities? If yes, please describe: _____

_____

Review of Systems/Medical History

Height: _____ Weight: _____

Are you currently pregnant and/or nursing? □ Yes □ No □ N/A

	Yes	No
Constitutional		
Sudden Weight Loss/Gain	□	□
Cardiovascular		
Heart Disease	□	□
High Blood Pressure	□	□
Stroke	□	□
Ear, Nose, Mouth, Throat		
Sjögren's Disease	□	□
Hearing Loss	□	□
Sinusitis	□	□
Respiratory		
Asthma	□	□
Chronic Bronchitis	□	□
COPD	□	□
Emphysema	□	□
Gastrointestinal		
Acid Reflux	□	□
Crohn's Disease	□	□
Genitourinary		
Prostate Disease	□	□

	Yes	No
Musculoskeletal		
Rheumatoid Arthritis	□	□
Osteoporosis	□	□
Joint Pain	□	□
Integumentary		
Shingles/Herpes Zoster	□	□
Cold Sores/Herpes Simplex	□	□
Rosacea	□	□
Neurological		
Seizures/Epilepsy	□	□
Tension Headaches	□	□
Migraines	□	□
Tumor	□	□
Multiple Sclerosis	□	□
Psychiatric		
ADHD	□	□
Anxiety	□	□
Depression	□	□

	Yes	No
Endocrine		
Type 1 Diabetes	□	□
Type 2 Diabetes	□	□
Hyperthyroidism (overactive)	□	□
Hypothyroidism (underactive)	□	□
Hematologic/Lymphatic		
Anemia	□	□
High Cholesterol	□	□
Leukemia	□	□
Allergic/Immunologic		
Seasonal Allergies	□	□
Lupus	□	□
HIV	□	□
Other:		
_____		
_____		
_____		

List any major surgeries: _____

_____

Family Medical History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	Yes	No	Relationship to you
Glaucoma	□	□	_____
Cataracts	□	□	_____
Macular Degeneration (AMD)	□	□	_____
Retinal Detachment/Hole/Tear	□	□	_____
Blindness	□	□	_____
Strabismus ("eye turn")	□	□	_____
Amblyopia ("lazy eye")	□	□	_____
Other _____	□	□	_____

	Yes	No	Relationship to you
Diabetes	□	□	_____
Cancer	□	□	_____
Heart Disease	□	□	_____
Hypertension	□	□	_____
High Cholesterol	□	□	_____
Kidney Disease	□	□	_____
Lupus	□	□	_____
Thyroid Disease	□	□	_____