

Dunes Eye Consultants

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Sex: M F

Marital Status: S M D W

Email address: _____

Phones:

Home: _____ Cell: _____ Work: _____

Employer: _____

Spouse's Name: _____ Birth Date: _____

Spouse's Social Security Number: _____ Work Number: _____

RESPONSIBLE PARTY INFORMATION (If other than patient)

Father's Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Phone: _____

Employer: _____ Phone: _____

Mother's Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Phone: _____

Employer: _____ Phone: _____

PATIENT PROBLEMS AND HISTORY

PLEASE CHECK ALL THAT APPLY:

Patient's Visual Problems

- Distance vision blurred
- Up-close vision blurred
- Double vision
- Flashes of light
- Floaters
- Redness
- Irritation
- Eye strain or headaches
- Color blindness
- Eye surgery/injury
- Cataracts
- Glaucoma
- Macular degeneration

OTHER _____

Patient's Health History

- Diabetes
- High blood pressure
- Heart problems
- High cholesterol
- Thyroid disease
- Ear, nose, throat disease
- Lung or respiratory disease
- Digestive or GI disease
- Arthritis or muscular disease
- Skin disease
- Headaches

OTHER _____

Family Health History

- Diabetes
- High blood pressure
- Macular degeneration
- Glaucoma
- Cataracts

OTHER _____

Please list all medications you are taking: _____

Are you allergic to any medications? Please list: _____

What other allergies do you have? _____

Do you consume alcohol products? Y N Do you consume tobacco products? Y N

How long ago was your last eye exam? _____

Name of clinic: _____

When did you last visit your medical doctor? _____

Name of clinic: _____

Do you currently wear contact lenses? Y N What type or brand? _____

Notice of Privacy Practices

Dunes Eye Consultants Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if we change our notice, you may obtain a revised copy by contacting our office. Dunes Eye Consultants provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Dunes Eye Consultants has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Dunes Eye Consultants reserves the right to change the Notice of Privacy Practices.
- You have the right to request how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.
- The patient may revoke this Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.
- Dunes Eye Consultants may condition treatment upon the execution of this Consent.
- By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations.

Date: _____ Signature of Patient or Responsible Party: _____

Signature on File for Insurance

I hereby authorize Dunes Eye Consultants to submit my insurance claims and that payment of authorized insurance benefits (including Medicare benefits) for any services furnished to me, be made on my behalf to Dunes Eye Consultants. I understand that I am responsible for any amount not covered by my insurance(s).

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: _____ Signature of Patient or Responsible Party: _____

PERIODIC REVIEW OF PERSONAL INFORMATION AND HEALTH HISTORY

If any information needs to be changed on the Personal Information and Health History form, draw a single line through the existing information, record the new information, record the date of the change and initial the change.

Review Date: _____ Signature of Patient or Responsible Party: _____

Review Date: _____ Signature of Patient or Responsible Party: _____

Review Date: _____ Signature of Patient or Responsible Party: _____

Review Date: _____ Signature of Patient or Responsible Party: _____