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Welcome to the HVEO Family

First Name: ______________________ Last Name: __________________________________ Middle Initial: _____ Preferred Name: ______________

Birth Date: _______________ Social Security Number: ______________________ Sex: **M / F** Email Address: ___________________________________

Home Address: ____ City: __________ State: ____ Zip: _______

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** Home Phone: ________________ Work Phone: _______________

Cell Phone: _____________ How were you referred to our office? _______________________ Do you have a facebook account? Yes No

Marital Status: **Single** **Married** **Other** ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: ____ Secondary Medical Insurance: _________________________________

Vision Insurance: ____ Insured Social Security Number: _______________________________

Insured's Birth Date:____ Insured's Employer: ____

Family Doctor: ____ Family Dr. Clinic/Phone: ______________________________________

Family Members: ____For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offerred a copy of Hardin Valley Eyecare & Optical's statement on privacy practices.
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Hardin Valley Eyecare & Optical to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Hardin Valley Eyecare & Optical to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection of past-due balances.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: ______________________________________ DATE: _____________________________________

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. **Medical Insurance will only cover** if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Loss of vision	**Floaters**	**Eye pain/soreness**	**Glare**	**Dry eyes**
Blurred vision	**Crossed eyes**	**Watery eyes**	**Light sensitivity**	**Red eyes**
Double vision	**Flashes of light**	**Sandy/gritty feeling**	**Tired eyes**	**Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* **Right** **Left** **Both**
Quality *How is it effecting you?* **Bothersome** **Aware** **Painful**
Severity *How severe is the problem?* **Mild** **Moderate** **Severe**
Duration *How long have you had the problem?* ______________________

Timing *Is it new, ongoing, returning?* **New** **Ongoing** **Returning**
Context *Associated w/:* **Infection** **Medical condition** **Injury** **Surgery**
Modifiers *Previous treatment?* **Drops** **Medication** **Other:** _________
Symptoms *Are there associated symptoms?* **Headache** **Other:** _________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
No problems **Diabetes** **High blood pressure** **Cancer**

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
No problems **Glaucoma** **Amblyopia** **Cataracts** **Macular degeneration** **Strabismus (eye turn)**

SOCIAL HISTORY

Do you smoke? **Y N**
If yes, what do you smoke? **Cigarettes Cigars Pipes**
How much per month do you smoke? ______________

Do you consume alcohol? **Y N**
If yes, how much do you drink? _________

What is your occupation? ___________________________

CURRENT VISION

__Glasses__: Do you currently wear glasses? **Y N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? **Single vision Bifocal Trifocal No-line (Progressive)**

Contacts: Do you want to be fitted/evaluated for contact lenses today? **Y N** Would you like to discuss your options for wearing contact lenses today? **Y N**

Do you currently wear contact lenses? **Y N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? **Soft Rigid**
What is the manufacturer/model of your contact lenses? _____________________________
What are the powers of your contact lenses (if you know)? _____________________________
How old are your current contact lenses? _____ **Months / Years**
How often do you replace your contact lenses? **Daily Weekly 2 weeks Monthly 3 months 6 months Annually**
What solutions do you use to care for contact lenses? **Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other:** _____

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder **Y NG**
- Surgery **Y N**
- Glaucoma **Y N**
- Amblyopia (lazy eye) **Y N**
- Cataract **Y N**
- Retinal problems **Y N**
- Macular degeneration **Y N**
- Strabismus (eye turn) **Y N**
- Patching **Y N**
- Other _______

Constitutional Problems
- Cancer **Y N**
- Fatigue **Y N**
- Developmental disability **Y N**
- Other _______

Ears, Nose, Mouth, Throat Problems
- Laryngitis **Y N**
- Dry mouth **Y N**
- Hearing loss **Y N**
- Sinusitis **Y N**
- Other _______

Neurological Problems
- Cerebral palsy **Y N**
- Multiple sclerosis **Y N**
- Tumor **Y N**
- Epilepsy **Y N**
- Other _______

Psychiatric Problems
- Depression **Y N**
- Other _______

Cardiovascular Problems
- Vascular disease **Y N**
- Stroke **Y N**
- Congestive heart failure **Y N**
- Heart disease **Y N**
- High blood pressure **Y N**
- Other _______

Respiratory Problems
- Emphysema **Y N**
- Bronchitis **Y N**
- Smoker **Y N**
- COPD **Y N**
- Asthma **Y N**
- Other _______

Gastrointestinal Problems
- Colitis **Y N**
- Chron's disease **Y N**
- Ulcer **Y N**
- Other _______

Genitourinary Problems
- Prostate disease/cancer **Y N**
- STD **Y N**
- Kidney disease **Y N**
- Other _______

Musculoskelatal Problems
- Ankylosis spondylitis **Y N**
- Fibromyalgia **Y N**
- Muscular dystrophy **Y N**
- Osteoarthritis **Y N**
- Other _______

Skin Problems
- Rosacea **Y N**
- Psoriasis **Y N**
- Eczema **Y N**
- Other _______

Endocrine Problems
- Insulin dependent diabetes **Y N**
- Hormonal dysfunction **Y N**
- Thyroid dysfunction **Y N**
- Non-insulin diabetes **Y N**
- Other _______

Blood/Lymph Problems
- Large volume blood loss **Y N**
- Anemia **Y N**
- Other _______

Allergy/Immunologic Problems
- Environmental allergies **Y N**
- Rheumatoid artheritis **Y N**
- Drug allergies **Y N**
- Lupus **Y N**
- Other _______

Do you sometimes experience dry eyes? **Y N**
Are your eyes sensitive to sunlight? **Y N**
Do you work at a computer ? **Y N**
Problems with reflections and/or glare? **Y N**
Prefer not to wear your glasses at times? **Y N**
Interested in newer contact lens technology? **Y N**
Want information on thinner / lighter lenses? **Y N**
Like information on LASIK vision surgery? **Y N**
Like a non-surgical option to correction? **Y N**
Participate in sporting activities / hobbies?

____

List any medications you are currently taking:

____
____
____
____

List any medicine allergies:

____

List any other allergies:

____
____

Are you currently pregnant or nursing? ***Y N***

HIPAA Notice

I have read and understand the HIPAA privacy notice (please sign below):

___________________________________ Date ____________________

Dilation

Dilation is an important component of every comprehensive eye examination. It requires the use of some eye drops that temporarily relaxes the colored part of one's eye (the iris), which in turn, allows your eye doctor to examine the back of the eye in its entirety. It takes about 10-15 minutes for the drops to take effect. Near vision will be blurry for a few hours along with an increased sensitivity to light. Distance vision is **not** relatively affected, except for the sensitivity to light.

Dilation aids in the detection of certain eye conditions like Glaucoma, Cataracts, Macular degeneration, and many more to list. Diabetic patients must have this performed once a year to make sure they do not have any diabetic eye disease.

If you have a systemic condition like diabetes, high blood pressure, or have been diagnosed with an eye condition or with a family history of an eye condition, it is recommended annually.

Optos Wide Field Retinal Imaging

Wide field retinal imaging allows us to take a photo of most of your retina. **This is a good alternative if you choose to not have dilation performed, however** it does not replace the effectiveness of dilation. **Some patients will still require dilation** if you have diabetes, other retinal diseases or if we are unable to obtain a clear photo. This is an excellent baseline photo to document what the back of your eyes look like at this point in time and can be referred to years down the road to see any subtle changes with your eye health. It is highly recommended to have this completed for every patient at least once.

This can be performed for a fee of $30 and cannot be applied to your insurance.

Please **check one** of the following:

____ I agree to have my eyes dilated or give permission to dilate my child's eyes.
____ I want to have wide field retinal imaging for a fee of **$30** and refuse the dilation drops.
____ I understand the importance of dilation and don't want to have it or imaging performed. I understand that some eye diseases will not be able to be detected with no dilation or imaging.

Please sign and date:

Name: ______________________________ Date: ________________