Welcome to Blue Ridge Eye Care, OD, PA

Patient Information and Payment Policy

Date _____

PATIENT INFORMATION						
	Name					
	DOB		Sex		SSN	
	Address					
	City		State		ZIP	
	Home Phone		Work		Cell	
	E-mail					
	Preferred Contact	Cell phone	E-mail	Text		
	Employer		Occupation			
	Emergency Contact	Name	Relationship		Phone	
	Preferred Language					
	How did you hear about Blue Ridge Eye Care?					

INSURANCE						
	Insured's Name		Relationship to Patient			
	DOB		SSN			
	Address					
	City		State		ZIP	
	Insured's Phone		Work		Cell	
	Medical Insurance		Vision Insurance			
	Member ID#		Member ID#			

Informed Consent for Retinal Imaging

As part of your eye health examination, we recommend a special diagnostic procedure wherein we take a digital image of the interior of your eye. This procedure is suggested for both adults and children. Retinal imaging is a valuable procedure for documenting the health of your eyes, and helps access your retina, optic nerve, macula and blood vessels. Retinal imaging makes it possible for us to document changes to your eyes, as additional images are taken in subsequent years.

In some cases, retinal imaging may be covered by your medical insurance. If your insurance does not cover retinal imaging, you will be responsible for paying the fee out of pocket. The private pay fee for retinal imaging is $32 for both eyes.

Please initial one of the following:

_____ DILATION & RETINAL IMAGING – $32 _____ RETINAL IMAGING ONLY – $32 _____ DILATION ONLY

Receipt of *Notice of Privacy Practices* and Consent to Treat

_____ **(Please initial.)** I hereby acknowledge that I have been provided with a copy of the *Notice of Privacy Practices* of Blue Ridge Eye Care, OD, PA for my own records.

_____ **(Please initial.)** I hereby acknowledge that I have been provided with a copy of the Financial Policy of Blue Ridge Eye Care, OD, PA for my own records.

With my signature, I authorize treatment by Blue Ridge Eye Care, OD, Pa. I authorize the release of medical information to treat my condition(s). I authorize any Medicare or other insurance payments for services or materials furnished to me to be made directly to Blue Ridge Eye Care, OD, PA. I understand that I am financially responsible for those charges not paid by my insurance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information required to process my Medicare claims.

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Patient Health History and Review of Systems

Patient Name _____ Date _____

REVIEW OF SYSTEMS	Date of Last Eye Exam		Date of Last Physical	
	Have you ever been diagnosed with any of the following? (Please circle all that apply.)			
	Constitution	Fatigue Syndrome	Developmental Disabilities	Cancer
	Ear, Nose, Throat	Sinusitis	Dry Mouth	Laryngitis	Hearing Loss
	Neurological	Tumor	Multiple Sclerosis	Cerebral Palsy	Stroke/CVA	Tumor	Epilepsy
	Psychiatric	Anxiety Disorder	Bipolar Disorder	ADD/ADHD	Depression
	Cardiovascular	Vascular Disease	Heart Disease	Congestive Heart Failure	Hypertension
	Respiratory	COPD	Bronchitis	Asthma	Emphysema	Sleep Apnea
	Gastrointestinal	Colitis	Acid Reflux	Ulcer	Celiac Disease
	Genitourinary	BPA	Hypertrophy	Pregnant	Nursing
	Musculoskeletal	Muscular Dystrophy	Osteoporosis	Gout	Arthritis	Fibromyalgia
	Integumentary	Eczema	Psoriasis	Rosacea	Cold Sores	Shingles
	Endocrine	Thyroid Dysfunction	Hormonal Dysfunction	Diabetes – Type I OR Type II	Last A1C _____
	Hematologic/Lymphatic	Ulcer	High Cholesterol	Anemia
	Immune	HIV/AIDS
	Allergy	Seasonal/Hayfever
	Other	Any other disease, illness, or condition (explain below)
	Ocular Health	Cataracts	Crossed Eyes/Lazy Eye	Eye Infections	Corneal Disease
		Double Vision	Floaters/Flashing Lights	Glaucoma	Iritis	Retinal Disease
	Family History	Has anyone in your family (blood relative) ever had any of the following?
		Glaucoma	Cataracts	Corneal Disease	Macular Degeneration
		Crossed Eyes/Lazy Eye	Diabetes	High Blood Pressure	Blindness
	Primary Care Physician				
	Pharmacy				

Please explain any circled items above: _____

_____

_____

Have you had surgery in the past 5 years, including eye surgery? Please explain. _____

_____

_____

Have you ever sustained an eye injury? Please explain._____

_____

Do you drive? _____ Do you smoke? _____Packs/day Do you consume alcohol?_____Drinks/day

Please list any prescriptions or over the counter medications you are currently using, including eye drops: _____

_____

_____

Medication Allergies _____

Reason for today's visit: _____

- Are you wearing contacts today? Y / N Brand: _____
- Are you interested in wearing contacts? Y / N
- Are you interested in LASIK? Y / N