eyecarecenter
OF COLORADO SPRINGS, PC

Part 1: Patient Information

Date _____ Patient Name _____

Address _____

City _____ State _____ Zip _____

Sex ☐Male ☐Female Height:_____ Weight:_____

Birthdate _____ Age _____

Whom May We Thank for Referring You?
_____

Marital Status: _____

Patient SS#: _____

Occupation: _____

Employer: _____

Spouse's Name: _____

Spouse's Birthdate: _____

Spouse's SS#: _____

Spouse's Occupation:_____

Spouse's Employer: _____

Preferred Language ☐English ☐ Spanish

Race ☐ American Indian or Alaska Native
☐Asian ☐Black or African American ☐Hispanic
☐Native Hawaiian/other Pacific Islander ☐White

Ethnicity: ☐Native Hawaiian/other Pacific Islander
☐Not Hispanic or Latino ☐Hispanic or Latino

Part 2: Insurance

Medical Insurance Company:

_____

Policy Holder's Name: _____

Relationship to Patient: ☐Spouse ☐Parent ☐Other

Policy Holder's DOB: _____

Vision Insurance Company: _____

Policy Holder's Name: _____

Relationship to Patient: ☐Spouse ☐Parent ☐Other

Policy Holder's DOB: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all the insurance submissions.

Responsible Party Signature: _____

Relationship _____

Date _____

Part 3: Phone Numbers

Home Phone _____Work Phone _____

Cell Phone_____

Best Number and Time to Call _____

EMERGENCY CONTACT *Specify someone who does not live in your household.*

Name _____Relationship_____
Home Phone _____

Part 4: Eye Health History

Date of Last Eye Exam_____

Name of Doctor_____

Do you wear glasses? ☐Yes ☐No

How frequently?

Do you wear contacts? ☐Yes ☐No

What type of contacts? _____

Hour's per day? _____

Describe problems you have with contacts_____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, Please enter your current e-mail address below

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Bloodshot Eyes	☐Yes	☐No	Dry Eyes	☐Yes	☐No	Loss of Vision	☐Yes	☐No
Blurred Vision – Distance	☐Yes	☐No	Eye Infection	☐Yes	☐No	Migraine Headaches	☐Yes	☐No
Blurred Vision – Near	☐Yes	☐No	Eye Injury	☐Yes	☐No	Night Vision, Poor	☐Yes	☐No
Burning Eyes	☐Yes	☐No	Eye Strain	☐Yes	☐No	Red Eyes	☐Yes	☐No
Cataracts	☐Yes	☐No	Fainting Spells, Blackouts	☐Yes	☐No	Seeing Halos	☐Yes	☐No
Color Vision, Poor	☐Yes	☐No	Floaters or Spots	☐Yes	☐No	Seeing Flashes	☐Yes	☐No
Crossed Eyes	☐Yes	☐No	Glaucoma	☐Yes	☐No	Temporary Loss of Vision	☐Yes	☐No
Discharge From Eyes	☐Yes	☐No	Headaches	☐Yes	☐No	Twitching Eyelid	☐Yes	☐No
Dizzy Spells	☐Yes	☐No	Itching Eyes	☐Yes	☐No	Poor Vision	☐Yes	☐No
Double Vision	☐Yes	☐No	Light Sensitive	☐Yes	☐No	Watering Eyes	☐Yes	☐No

PART 5: Medical History

Name of Physician_____ Date of Last Visit _____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING. ALSO MARK IN THE APPROPRIATE COLUMN TO INDICATE IF A BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING PROBLEMS:

Condition	**Yourself**	**Blood Relatives**
AIDS/HIV	☐Yes ☐No	☐Yes ☐No
Arthritis	☐Yes ☐No	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	☐Yes ☐No
Artificial Joints	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No
Blindness	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No
Cataracts	☐Yes ☐No	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No
Drug Sensitivity	☐Yes ☐No	☐Yes ☐No
Emphysema	☐Yes ☐No	☐Yes ☐No
Epilepsy	☐Yes ☐No	☐Yes ☐No
Glaucoma	☐Yes ☐No	☐Yes ☐No
Eye Surgery	☐Yes ☐No	☐Yes ☐No
Hay Fever	☐Yes ☐No	☐Yes ☐No
Heart Condition	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No
High Cholesterol	☐Yes ☐No	☐Yes ☐No
Lupus	☐Yes ☐No	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	☐Yes ☐No
Migraine Headaches	☐Yes ☐No	☐Yes ☐No
Multiple Sclerosis (MS)	☐Yes ☐No	☐Yes ☐No
Pacemaker	☐Yes ☐No	☐Yes ☐No
Poor Color Vision	☐Yes ☐No	☐Yes ☐No
Retinal Disease	☐Yes ☐No	☐Yes ☐No
Shingles	☐Yes ☐No	☐Yes ☐No
Skin Conditions	☐Yes ☐No	☐Yes ☐No
Stroke	☐Yes ☐No	☐Yes ☐No
Thyroid Conditions	☐Yes ☐No	☐Yes ☐No
Tuberculosis	☐Yes ☐No	☐Yes ☐No
Turned Eye	☐Yes ☐No	☐Yes ☐No
Tobacco use	☐None ☐Former Smoker ☐Current Everyday Smoker ☐Current Someday Smoker	
Alcohol Use	☐None ☐Social Use Only ☐ 1-2 Drinks Daily ☐Above Average Use ☐Alcohol Dependence	

Are you Pregnant? ☐Yes ☐No Number of Children: _____

Medications

List medications you are currently taking, including eye drops:_____

_____

ALLERGIES *List your allergies to medications or other substances*_____

Part 6: Patient Disclosure Allowances

Eye Care Center of Colorado Springs does our best to abide by all HIPAA regulations which include patient privacy. In order to ensure we are complying with your wishes, please fill out the following information. We will keep this information on file and may ask you to update this annually.

You may call or text me at the below listed numbers, please do/do not leave detailed information.

_____ Please leave a detailed message: Yes No

_____ Please leave a detailed message: Yes No

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I _____ understand that I have the right to revoke this authorization in writing at any time. I understand that revocation does not affect any past person or entity which was already provided information. I understand that the information used or disclosed may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature Date

Part 7: Acknowledgement of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a detailed description of the uses and disclosures of my health information. I understand that the Eye Care Center of Colorado Springs has the right to change the Notice of Privacy Practices from time to time and that I may contact the Eye Care Center of Colorado Springs at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the Eye Care Center of Colorado Springs restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the Eye Care Center of Colorado Springs is not required to agree to my requested restrictions; however, if agreed upon, the Eye Care Center of Colorado Springs is bound to abide by such restrictions.

_____ _____

Patient Name Relationship to Patient

_____ _____

Signature Date

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, however was unable to do so as documented below.

Date:	Initials:	Reason: