First **Last** **Date**

Phone **Email**

Mailing Address _____

Last 4 Numbers of your SSN (if using insurance)_____ **Gender:** ☐ Male ☐ Female ☐ Other

Date of Birth_____ **Last Eye Exam**_____

Reason for today's visit (circle one): ☐ Eyeglasses ☐ Contact Lenses ☐ Lasik Consult ☐ Medical Visit

Check all of the items that apply to you:

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Mucous Discharge
- ☐ Blurry Vision
- ☐ Eye Strain (Tired Eyes)
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Vision Loss
- ☐ Distorted Vision
- ☐ Dryness
- ☐ Gritty Feeling
- ☐ Flashes
- ☐ Styes
- ☐ Eye Surgery
- ☐ Chronic Infection

Review of Systems (Please check any of the following that apply): ☐ None below Apply

Constitutional
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Other _____

Ear / Nose / Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Other _____

Neurological
- ☐ Multiple Sclerosis
- ☐ Tumor
- ☐ Migrane
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other _____

Cardiovascular
- ☐ Hypertension
- ☐ Stroke / CVA
- ☐ Heart Disease
- ☐ Other _____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Other _____

Gastrointestinal
- ☐ Acid Reflux
- ☐ Other _____

Genitourinary
- ☐ Kidney Disease
- ☐ STD - Herpetic / Chalamydia
- ☐ Other _____

Musculoskeletal
- ☐ Osteoarthiritis
- ☐ Ankylosing Spondylitis
- ☐ Gout
- ☐ Other _____

Skin
- ☐ Eczema
- ☐ Rosacea
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles
- ☐ Other _____

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid Dysfunction
- ☐ Other _____

Hemological / Lymphatic
- ☐ Anemia
- ☐ Hypercholesteremia
- ☐ Other _____

Allergy / Immunological
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Other _____

Due to recent changes in healthcare, additional information must be obtained to be compliant with Federal requirements. If you feel uncomfortable answering any specific questions, please let your technician know and you may discuss it with your eye doctor.

Current medications _____

Medication Allergies_____

Preferred Language: ☐ English ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Hispanic ☐ Caucasian

Ethnicity: ☐ Hispanic / Latino ☐ Native Hawaiian or Other Pacific Island ☐ Not Hispanic / Latino

Height _____ **Weight** _____

Do you currently drink alcohol? ☐ Yes, amount how often?_____ ☐ No

Do you currently smoke tobacco? ☐ Yes, amount how often?_____ ☐ Never

How many years?_____ ☐ Former Smoker

Do you currently use illegal drugs? ☐ Yes, amount how often?_____ ☐ No

Exposed to or infected with any sexually transmitted disease? ☐ Yes ☐ No

Are you pregnant and / or nursing at this time?_____

History of Family Eye Disease:

	You	Family	
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Glaucoma	☐	☐	_____
Diabetic Retinopathy	☐	☐	_____
Strabismus	☐	☐	_____
Retinal Detachment	☐	☐	_____
Other Eye Disease	☐	☐	Explain_____

Do you wear Contact Lenses? Yes No **If yes, which brand?** _____

Who is your Primary Care Physician (PCP)?_____

PCP Phone Number?_____ **PCP Fax Number?**_____

NOTICE OF PRIVACY PRACTICE & INSURANCE

As a summary, the law requires that Resolution Eyecare make every effort to inform you of your rights related to your personal health information. The HIPAA notice of privacy practice protects your privacy rights. We will not release your information unless it directly involves your care.

A copy of Resolution Eyecare's Notice of Privacy Practice is made available to me and I acknowledge agree that I have been informed that this office abides by the HIPAA laws and am entitled to a copy of the policy for review upon request.

I understand that Resolution Eyecare may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and or type of products provided) to another party to permit the Office to perform its administrative duties, provide me with eye care services and products, process my vision and medical benefits claims and communicate with me regarding vision care services/products provided by the Office (for example, mailings of exam reminders or information about services and products that I have received from the Office.) I can be assured that this Office does not sell my personal information of any kind to a third party for such party's own use.

I authorize this Office to submit my vision /medical claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Office.

X_____ _____
Patient Signature or Patient Legal Representative Date

I **authorize Resolution Eyecare to release** my complete medical records and other documentation made by doctors or personnel for the entire time I was treated by the Practice **to the following family members, friends, or other care givers** who contact us for the purpose of providing them with information related to my treatment and or payment obligations.

Name_____ Relationship_____ Phone_____

I understand that Resolution Eyecare may need to contact me for purposes related to my treatment, appointments, referrals, and billing business.

I authorize the use of my contact information. I understand I can revoke the authorization at any time.

☐ Text ☐ Phone ☐ Email ☐ Any method is acceptable

X_____ _____
Patient Signature or Patient Legal Representative Date

NOTICE OF INSURANCE ACCEPTANCE *(Only applies to patients using insurance)*
At Resolution Eyecare, we strive to understand, accept, authorize, and properly process your insurance benefits. All co-pays and non-covered services are due at the time of the appointment. All benefits quoted are not a guarantee of payment by your insurance and final determination can only by made when the claim is processed. Ultimately, you are the responsible party for payment of all services and products rendered.

X_____ _____
Patient Signature or Patient Legal Representative Date

*Any eyeglasses or contact lens re-checks past ninty (90) days of the initial eye exam are subject to a refraction fee of $40. Purchased contact lens boxes that are unopened, unmarked, and undamaged can be refunded or exchanged within ninty (90) days of purchase. Contact lenses purchased through insurance can only be exchanged. Specialty contacts, hard contacts, or custom contacts cannot be returned or refunded.