Welcome to Art For Eyes Optical

SHEILA D. MERRITT, O.D.
Phone (904) 644 – 8873 Fax (904) 644 – 8915

Name _____ Male / Female
Last First Middle Initial

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____

Birthdate_____Age_____ Work Phone_____

Occupation _____ Place of Employment/School_____

If married, spouse's name_____ If child, parent's name_____

E-mail Address _____

If paying by check, driver's license #_____ State_____

Emergency contact: Name _____ Phone#_____

HIPAA (Health Insurance Portability and Accountability Act)**:** I have read and understand the office HIPAA policy (attached to clipboard). Signature below is only acknowledgment that I have seen and read this policy.

Patient (or guardian) signature _____ Date_____

Vision Insurance:
I understand that verification of coverage must be done PRIOR to exam/services. Otherwise, patient will be responsible for filing of insurance benefits.

Patient signature_____ Date_____

NOTE: We are providers for many insurance plans. Please present card & valid ID at front desk.

Plan name_____ Policy #_____

Patient's Social Security#_____ Patient's DOB_____

Responsible member (if different than patient): Name_____

Medical information release: I request that payment of authorized insurance be made either to me or on my behalf to Dr. Sheila Merritt for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the health care administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date_____

Eye History:
Reason for today's visit_____ Date of last exam_____

Any special eye or vision problems_____

List any previous eye injuries or surgeries_____

Does your work require special vision care? Explain_____

Please list hobbies/activities that may require special vision care_____

How did you hear about our office?_____

Contact Lens Info:

Do you desire an evaluation for contacts &/or update contact Rx today? ____yes ____no
Do you currently wear contact lenses? ___ yes ___no Or have you worn them before? ___yes ___no
If yes, what kind? ___soft ___ rigid ___disposables ___monovision ___bifocal ___astigmatic(torics)
Which brands have you worn?_____ How many years have you worn contacts?_____
Do you sleep in your contact lenses? ___yes ___no Or do you remove them nightly? ___yes ___no
What solutions do you use?_____

Medical History:

Below are questions about your ocular and family medical history. Due to your eyes being directly affected by your general health, medical problems, and the medications you take, please answer completely so we can better care for your visual needs.

Eye conditions/symptoms ***you*** have (or have had):

Blurred vision___	cataracts___	glaucoma___	dry eyes___	floater/spots___
Double vision___	eye pain___	redness____	itching____	tearing_____
Eyelid problems___	halos___	infection___	blindness___	eye injury___
Retinal problems___	lazy eye___	flashes____	light sensitivity_____	
Eye color_____			macular degeneration____	

Do ***you*** have (or have had)?

Diabetes___	High blood pressure___	Heart disease___
Headache___	High cholesterol___	Thyroid disease___
Asthma___	Lung disease___	Kidney disease___
Arthritis___	Skin disorder___	Gastrointestinal disorder___
Stroke___	Cancer___	Neurological ___
Anemia___	Seizure___	Auto Immune disease____
Hay fever___	Sinus problems___	HIV positive___

Are you pregnant or nursing? Yes_____ No_____

Are you taking any *medications* (including over-the-counter meds, vitamins, and herbal supplements)? ___yes ___no
Please list_____
_____
_____

Are you allergic to any *medications*? ___yes ___no List_____
_____

Do you have allergies (seasonal, etc.)? ___yes ___no List_____

Medical doctor _____ Last visit _____
Medical doctor's phone #_____

Does anyone in your ***family*** have any of the following medical problems?

Diabetes_____	High blood pressure____	Heart disease_____
Migraines_____	High cholesterol_____	Thyroid problems_____
Cancer_____	Glaucoma_____	Cataracts_____
Blindness_____	Color deficiency_____	Retinitis Pigmentosa____
Macular Degeneration _____		Other_____

Dilation:

Although we can determine a spectacle prescription without a dilated fundus exam, this only provides a limited view of the inside of your eye and some very serious conditions may go undetected including, but not limited to, retinal holes, tears, and detachments. Drops are placed in the eyes to enlarge the pupils. This dilation usually lasts for 2-6 hours. During this time, your eyes will be sensitive to light and your vision may be blurry, especially at near. This procedure is included in your comprehensive eye exam.

_____ I can have this procedure today.

_____ I am unable to do this procedure today and need to reschedule it.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations. (§ 164.508 (a))

I, _____ (Patients Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

* a basis for planning my care and treatment.
* a means of communication among the health professionals who may contribute to my healthcare.
* a source of information for applying my diagnosis and surgical information to my bill.
* a means by which a third party payer can verify that services billed were actually provided.
* a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Signature of Individual or Legal Representative Witness

_____

Date _____