LAKE DILLON EYE CARE

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Mailing address: _____ **City:** _____ **State:** _____ **Zip:** _____

DOB: _____ **Age:** ____ **Cell Phone:** _____ **Work Phone:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____ **E-mail:** _____

Account Responsible
If patient is a minor / Isn't primary on insurance

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Mailing address: _____ **City:** _____ **State:** _____ **Zip:** _____

DOB: _____ **Age:** ____ **Cell Phone:** _____ **Work Phone:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____

Insurance Information

Name of Primary Insurance: _____ **Policy ID #:** _____ **Group #:** _____

Subscriber's Name: _____ **Subscriber's DOB:** _____ **Subscriber's SSN:** _____

Emergency Contact

Last Name: _____ **First Name:** _____ **Cell Phone:** _____ **Relation:** _____

Mailing address: _____ **City:** _____ **State:** _____ **Zip:** _____

□ Check here to authorize Lake Dillon Eye Care to release Protected Health Information (PHI) to this contact.

I request that payment of authorized insurance carrier benefits be made either to me, or on my behalf, to Lake Dillon Eye Care, Prof., LLC, for any services rendered by the staff. I authorize the release of my medical information to any insurance carrier, their agents, and billing services that I, or Lake Dillon Eye Care, Prof., LLC, have contracted with, to determine benefits. I have received a copy of the Notice of Medical Information Privacy Rights from Lake Dillon Eye Care. I realize if insurance information is incorrect at time of service, I will be responsible for payment and billing.

_____ _____

Patient/Guardian Signature **Date**

LAKE DILLON EYE CARE

PATIENT HISTORY

Patient's Name: _____ Patient's DOB: _____ Primary Physician: _____

Preferred Pharmacy: _____ Last Eye Exam: _____

Review of Systems: Please check all that apply

Constitutional Symptoms
- □ Fever
- □ Weight loss / gain (circle)
- □ Trouble sleeping/insomnia

Cardiovascular
- □ Congestive heart failure
- □ Heart attack/Coronary stent
- □ Arrhythmia: _____
- □ High blood pressure
- □ Elevated cholesterol
- □ Bypass surgery
- □ Pacemaker/ICD

Ears, Nose, Mouth & Throat
- □ Hearing problems/Tinnitus
- □ Sinus Congestion

Respiratory
- □ Emphysema
- □ Asthma
- □ Lung cancer
- □ Sleep Apnea
- □ COPD
- □ Oxygen use

Gastrointestinal
- □ Hepatitis
- □ Ulcers/Bleeding
- □ Stomach/Colon cancer
- □ GERD

Genitourinary
- □ Kidney disease
- □ Cervical cancer
- □ Ovarian cancer
- □ Uterine cancer
- □ Current pregnancy
- □ STI: _____

Neurological
- □ Fainting/Dizziness
- □ Migraines/Headaches
- □ Concussion
- □ Convulsions/Seizure/Epilepsy
- □ Stroke/Paralysis
- □ Tumor
- □ Alzheimer's
- □ Parkinson's

Musculoskeletal
- □ Degenerative arthritis
- □ Rheumatoid arthritis
- □ Lupus
- □ Fibromyalgia
- □ Multiple sclerosis

Integumentary (Skin/Breasts)
- □ Breast cancer
- □ Skin cancer
- □ Eczema
- □ Psoriasis

Allergic/Immunologic
- □ Seasonal/General Allergies
- □ Lupus
- □ Immune disorders

Psychiatric
- □ Depression
- □ Anxiety
- □ Schizophrenia

Hematologic/Lymphatic
- □ Anemia
- □ Sickle Cell disease
- □ Bleeding disorder
- □ Leukemia/Blood cancer

Endocrine
- □ Diabetes I or II (circle)
- □ Thyroid issues

Eyes
- □ Blurry vision (near / mid / far)
- □ Burning
- □ Dryness
- □ Double vision
- □ Tearing/watering/scratching
- □ Glare/Light sensitivity
- □ Itching
- □ Loss of side vision
- □ Loss of vision
- □ Pain/Soreness
- □ Redness
- □ Skin disease/Shingles

Contacts
- □ Current wearer
- □ Interested in contacts

LASIK
- □ Interested in LASIK

Social History
- □ Drug use

  Frequency: _____
- □ Alcohol

  Frequency: _____
- □ Tobacco

  Frequency: _____
  - □ Former smoker
  - □ Never smoker
- □ Marijuana

  Frequency: _____

Eye History (Self or Family)

□ Cataract	□ Eye Muscle Problems	□ Eyelid Problems
When Diagnosed: _____	When Diagnosed: _____	When Diagnosed: _____
Treatment: _____	Treatment: _____	Treatment: _____
Familial Relation: _____	Familial Relation: _____	Familial Relation: _____
□ Glaucoma	□ Retina Problems	□ Other: _____
When Diagnosed: _____	When Diagnosed: _____	When Diagnosed: _____
Treatment: _____	Treatment: _____	Treatment: _____
Familial Relation: _____	Familial Relation: _____	Familial Relation: _____

Family History: Describe any major illness or hereditary problems of parents, grandparents, brothers, or sisters.

_____

_____

Current Medications

_____

_____

_____

Current Eye Drops / Eye Medications

_____

_____

_____

Allergies to Medications

_____

_____

How often do you experience any of these symptoms? Please circle your answer.

Headaches: You get headaches of any severity each week or your headaches tend to get worse later in the day.

Never **Rarely** **Sometimes** **Very Often** **Always**

Neck & Shoulder Pain/Stiffness: Pain/tension when you work on the computer or read.

Never **Rarely** **Sometimes** **Very Often** **Always**

Discomfort with Computer Use: Your eyes get tired, burn, or get red when you do long hours of computer work.

Never **Rarely** **Sometimes** **Very Often** **Always**

Tired Eyes: Your eyes feel increasingly fatigued/tired as the day goes on.

Never **Rarely** **Sometimes** **Very Often** **Always**

Dry Eye Sensation: Your eyes progressively feel dry/sandy/gritty while working on the computer or reading.

Never **Rarely** **Sometimes** **Very Often** **Always**

Light Sensitivity: Bright/Strong lights (vehicle headlights, florescent lights, etc.) bother you.

Never **Rarely** **Sometimes** **Very Often** **Always**

Dizziness: You experience dizziness, motion sickness, or vertigo.

Never **Rarely** **Sometimes** **Very Often** **Always**

_____ _____

Patient/Guardian Signature **Date**

LAKE DILLON EYE CARE

CONTACT / FINANCIAL / HIPAA CONSENT FORMS

Lake Dillon Eye Care (LDEC) staff often contact patients by phone, text, or e-mail. If we are not able to speak with you directly, we leave messages when possible. In order to protect your privacy, it is LDEC's policy to not leave messages with anyone other than the patient or legal guardian, and not leave specific information on an answering machine without written permission.

You will not be "spammed" via text, e-mail, or phone. These methods of contacting you are strictly for office efficiency, and for your convenience.
By signing this document, you will automatically be opted-in to text and e-mail notifications, and you have the ability to opt-out at any time.
If you receive messages from us, you can reply to them with the word "stop" to opt out.

You have the option to change your contact preferences at any time by completing a new consent form.

Please read each section carefully and sign.

Office Policies

Please sign in at the front desk upon arrival and present your current insurance card(s). If the insurance information is incorrect or inactive, you will be responsible for payment and submission of charges to the correct insurance plan. If you are late for your appointment by more than ten minutes, we will do our best to accommodate you, but, on certain days, it may be necessary to reschedule your appointment. We strive to minimize wait time, **but emergencies occur, and will take precedence over a scheduled appointment**. For medication refills, we require a twenty-four-hour notice during regular business hours. We reserve the right to apply a no-show fee to patients who fail to notify us of cancellation at least twenty-four hours before their scheduled appointment.

Insurance & Finance

You are responsible for any, and all, co-payments, deductibles, and coinsurances. It is your responsibility to understand your benefit plan, what services are covered, and to know if a written referral or authorization is required prior to an office visit. If our practice does not participate in your insurance plan, payment, in full, is expected from you at the time of your appointment; we will supply an invoice that can be submitted to your insurance provider for reimbursement. Patient-responsible balances are billed immediately upon receipt of your insurance explanation of benefits (EOB). Your remittance is due within fifteen days of receipt of your bill. Any account balance outstanding ninety days will be forwarded to a collection agency. Outstanding balances must be paid prior to a new appointment being scheduled. LDEC accepts payment via cash, check, debit card, Care Credit, and all major credit cards. Self-paying patients are expected to pay, in full, at time of service.

Materials

Prescription lenses are custom-made medical devices. Frames that have had prescription lenses inserted in them are not refundable. Prescription lenses made by LDEC may be refunded up to 50%, within 60 days, if the patient fails to adapt. Contact lenses may be price-matched with 1800contacts.com only, and the patient must present documentation upon purchase. Rebates exclusive to LDEC will not be applied to materials that have been price-matched.

_____ **Please initial here to indicate you have carefully read and understand the Materials section above.**

_____ _____

Patient/Guardian Signature **Date**

LAKE DILLON
EYE CARE

optomap®
ultra-widefield retinal imaging

An Announcement from Lake Dillon Eye Care

We are pleased to inform you that during this visit at Lake Dillon eye Care, you will experience the benefits of the latest technology in eye care – **Optomap®**. **Optomap** is a tool that assists us in the evaluation of your retina. With **Optomap**, we can discover any abnormalities or confirm the health of your retina, diagnose any potentially harmful diseases, and if necessary, determine the best course of action.

An annual comprehensive eye exam is an important component of your health care regimen. These yearly check-ups enable us to test your vision and examine the inside and back area of your eye, known as the retina. The sensitive tissue that makes up the retina is susceptible to a variety of diseases that could lead to loss of vision or in some cases blindness. The early detection of any retinal abnormality is crucial to maintaining your ocular and systemic health because in most cases of eye disease, in the early stages, you will experience no signs or symptoms.

Optomap is a simple, non-invasive procedure. In less than a half a second, we can generate a high-resolution, digital, color image of your retina. This image becomes a part of your permanent medical record and enables us to see more of your retina, measure aspects of your eye, and magnify some of the finer details. We can also track changes in your eye over time by comparing each year's optomap. In addition, you take a more active role in your eye care by reviewing the images with your doctor and learning more about how best to protect your vision. If you are interested in learning more about the optomap, please visit www.optomap.com.

- ☐ Yes, I am interested in utilizing the Optomap™ retinal imaging device.
- ☐ Not sure, I have more questions.