FORRESTER EYE ASSOCIATES

Dr. Van C. Forrester
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Patient Basics

When was your last eye exam? ___-___-____

What brings you in today? ◯ Eye Exam ◯ Contact Exam (Have you ever worn contacts? Yes ◯ No ◯)

◯ Medical Check (Reason for medical check) _____

Last Name: _____ First Name: _____ Middle: _____

Marital Status: _____ Social Security #: _____ DOB:(___/___/___)

Sex: _____ Language: _____ Race: _____ Ethnic Group: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Preferred Phone (check one): Home ◯ Work ◯ Mobile ◯ **Patient would like to receive text? Yes ◯ No ◯

*Email Address: _____ **Your email is used for your personal patient portal.*

Address: _____

City: _____ State: _____ Zip: _____

Employer's Name: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Financial Responsibility

- I understand and accept financial responsibility for all services rendered to me.
- I understand my insurance company is billed as a courtesy to me and payment of any bill is my responsibility.
- I understand if incorrect information is provided the bill is my responsibility.
- I permit a copy of this authorization to be used in place of the original as my signature on file and request payment of insurance benefits to Forrester Eye Associates, Dr. Van Forrester.

Patient's or Guardian's Signature: _____ Date: _____

Parent/legal guardian Information if patient under 18

Name: _____ Age: _____ DOB:(___/___/___)

Address: _____ Phone:_____

Social Security #: _____ Sex: _____ Relationship to Patient: _____

Authorization to Disclose Protected Health Information

It is our policy to Keep all matters regarding our patients in strict confidence due to HIPPA law. If you wish to have any of your relatives or close friends obtain your information regarding your medical records please list them below.

Persons I authorize to obtain medical information for me.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's or Guardian's Signature: _____ Date: _____

Insurance Information

We are required to follow proper coding and billing guidelines for eye examinations. Vision plans provide you with a "well vision" examination. This assumes healthy eyes that only suffer from focusing problems like nearsightedness, farsightedness, astigmatism and presbyopia. Any medical conditions affecting the eyes (allergies, high blood pressure, macular degeneration, glaucoma, high risk medication, dry eyes, cataracts, diabetes, etc.) are not covered by vision plans.

Your medical insurance will not pay for vision problems; your vision plan will not pay for medical problems.

We also require a current insurance card and ID at time of service to be provided to the front desk at check out.

MEDICAL INSURANCE

Name of Plan: _____
Primary Insured Person: _____
Relation to Patient: Self • Spouse • Parent
Primary's DOB: _____
Policy Number: _____
Primary's Employer: _____

VISION INSURANCE

Name of Plan: _____
Primary Insured Person: _____
Relation to Patient: Self • Spouse • Parent
Primary's DOB: _____
Policy Number: _____
Primary's Employer: _____

SECONDARY MEDICAL INSURANCE: _____ Policy Number: _____

Pharmacy/Doctor Information

Pharmacy: _____ **Phone:** _____ **City:** _____ **State:** _____

Doctor: _____ **Phone:** _____ **City:** _____ **State:** _____

Retinal Photography and Dilation

Retinal Photography - Please read the laminated form and decide if you want digital imaging of the back of your eyes.

◯ **I do want retinal photos. - I recognize that this is an elective service and may not be covered by insurance and I may be responsible for payment of $35.00.**

◯ **I do not want retinal photos.**

Dilation

◯ **I do want to be dilated. *Last time you were dilated? _____**

◯ **I do not want to be dilated. *In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.**

I certify that the above is my complete medical and eye history to the best of my knowledge.

_____ Date: _____ / _____ / _____

Patient Signature (Parent/legal guardian if patient under 18)

Privacy Practice Acknowledgement

The full Notices of Privacy Practices of Forrester Eye Associates is available by request from our check-in desk, and is also available online at www.forrestereye.com. 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 or indirectly. • Obtain payment from third-party payers. • Conduct normal healthcare operations such as quality assessments and physician certifications. I understood that the full Notice of Privacy Practices of Forrester Eye Associates contains a more complete description of the uses and disclosures of my health information and is available upon request. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Print Patient's Name (Parent/legal guardian if patient under 18)/: _____

_____ Date: _____ / _____ / _____

Patient Signature (Parent/legal guardian if patient under 18)

Patient's Name: _____

Past Medical History

Mark of any of the following Medical conditions that you have been diagnosed with and date of diagnosis

- ◯ Anxiety _____
- ◯ Arthritis _____
- ◯ Asthma_____
- ◯ Atrial fibrillation_____
- ◯ Bone Marrow Transplant _____
- ◯ BPH _____
- ◯ Breast Cancer_____
- ◯ Colon Cancer _____
- ◯ COPD _____
- ◯ Coronary Artery Disease _____
- ◯ Depression _____
- ◯ Diabetes (Type 1 or 2)_____
- ◯ End Stage Renal Disease _____
- ◯ GERD _____
- ◯ Hearing Loss _____
- ◯ Hepatitis _____
- ◯ High Blood Pressure _____
- ◯ HIV/AIDS _____
- ◯ Hypercholesterolemia _____
- ◯ Hyperthyroidism _____
- ◯ Hypothyroidism_____
- ◯ Leukemia _____
- ◯ Lung Cancer _____
- ◯ Lymphoma _____
- ◯ Prostate Cancer _____
- ◯ Radiation Treatment _____
- ◯ Seizures _____
- ◯ Stroke _____
- ◯ NONE
- ◯ OTHER: _____

Height:_____ Weight_____

Past Surgeries

Mark of any of the surgeries you have had on the following organs, and date.

- ◯ Appendix Removed _____
- ◯ Bladder _____
- ◯ Breast Biopsy (Right/Left) _____
- ◯ Breast Reduction _____
- ◯ Breast Implants _____
- ◯ Colectomy_____
- ◯ Colectomy (Diverticulitis) _____
- ◯ Colectomy (IBD) _____
- ◯ Coronary Artery Bypass _____
- ◯ Gallbladder Removed _____
- ◯ Heart - PTCA _____
- ◯ Heart - Mechanical Valve Replacement _____
- ◯ Heart - Biological Valve Replacement _____
- ◯ Heart Transplant _____
- ◯ Joint Replacement Knee (Right/Left/Both) _____
- ◯ Other_____
- ◯ Joint Replacement Hip_____
- ◯ Kidney Biopsy (Right or Left) _____
- ◯ Kidney Stone Removal (Right or Left) _____
- ◯ Kidney Transplant_____
- ◯ Liver – Hepatectomy _____
- ◯ Liver Transplant or Shunt _____
- ◯ Ovaries Removed (Endometriosis) _____
- ◯ Ovaries Removed (Cyst) _____
- ◯ Ovaries Removed (Ovarian Cancer) _____
- ◯ Prostate Removed (Prostate Cancer) _____
- ◯ Prostate Biopsy _____
- ◯ Spleen _____
- ◯ Testicles (Right/Left/Both) _____
- ◯ Hysterectomy (Fibroids) _____
- ◯ Hysterectomy (Uterine Cancer) _____
- ◯ None

Ocular Medical History

Mark of any of the following ocular conditions that you have been diagnosed with, date of diagnosis, and circle eye effected – Right R – Left L – Both B

- ◯ Allergic Conjunctivitis (R – L – B) _____
- ◯ Blepharitis (R – L – B)_____
- ◯ Cataract (R – L – B) _____
- ◯ Contact Lens (R – L – B)_____
- ◯ Corneal Dystrophy (R – L – B) _____
- ◯ Diabetic Retinopathy, Background (R – L – B)_____
- ◯ Diabetic Retinopathy, Proliferative (R – L – B)_____
- ◯ Dry Eyes (R – L – B)_____
- ◯ Glasses (R – L – B)_____
- ◯ Glaucoma (R – L – B) _____
- ◯ Macular Degeneration (R – L – B)_____
- ◯ Macular ERM (R – L – B) _____
- ◯ Narrow Angles (R – L – B)_____
- ◯ Ocular Hypertension (R – L – B) _____
- ◯ Pseudoexfoliation (R – L – B)_____
- ◯ Retinal Tear (R – L – B)_____
- ◯ Strabismus (R – L – B)_____
- ◯ P V D (R – L – B)_____
- ◯ Vitreous Floaters (R – L – B)_____
- ◯ Other _____

Patient's Name: _____

Ocular Surgeries History

Mark of any of the following ocular surgeries that you had, date, and circle eye effected – Right R – Left L – Both B

◯ Blepharoplasty (R – L – B) _____
◯ Cataract Surgery (R – L – B)_____
◯ Corneal Transplant (R – L – B) _____
◯ DSAEK (R – L – B)_____
◯ Eye Muscle Surgery (R – L – B) _____
◯ Intravitreal Injections (R – L – B)_____
◯ LASIK (R – L – B)_____
◯ LPI (R – L – B) _____
◯ LTP (R – L – B)_____
◯ PRK (R – L – B) _____
◯ Ptosis Repair (R – L – B)_____
◯ Punctal Plugs (R – L – B) _____
◯ Strabismus Surgery (R – L – B)_____
◯ Retinal Laser (R – L – B) _____
◯ Trabeculectomy (R – L – B)_____
◯ Tube Shunt (R – L – B) _____
◯ Yag Capsulotomy (R – L – B)_____

Medications

*** Name, Dosage, and Frequency***

_____

_____

_____

Allergies

Please describe reaction for each allergy.

_____

_____

Social History

Your smoking status: ◯ Former Smoker – Started smoking date: _____ Quit smoking date: _____

◯ Current Smoker – When did you start smoking? _____ Packs per day? _____
◯ Never Smoked

Have you ever used drugs? ◯ Yes ◯ No If yes what type? _____IV drug use? ◯ Yes ◯ No
Do you drink alcohol? ◯ Yes ◯ No How many drinks per day? _____
How many times have you have more than 5 drinks per day in the last year? _____

Do you feel safe at home? ◯ Yes ◯ No
Do you drive in the day time? ◯ Yes ◯ No
Do you drive at night? ◯ Yes ◯ No
Do you Exercise? ◯ Several times a day ◯ once a day ◯ A few times a week ◯ A few times a month ◯ Never
Caffeine intake? ◯ Several times a day ◯ once a day ◯ A few times a week ◯ A few times a month ◯ Never

Family History

Condition	*Family Member*
◯ Diabetes	_____
◯ High Blood Pressure	_____
◯ Heart Disease	_____
◯ Thyroid	_____
◯ Retinal Disease	_____
◯ Blindness	_____
◯ Glaucoma - Maternal/ Paternal?	_____
◯ Macular Degeneration	_____