The Eye Site of Bluffton

Follow My Health
"The Electronic Patient Portal"

This allows you to:

- Ask a question to our Doctors
- Receive a secure message from our Doctors
- Receive an electronic medical record of your visit

In order for you to have access to these online features, we will need your email address. Once you have received a link to your health records via email, you may view your health records through that link. Please ask if you have any questions.
Please complete the bottom of this form with your information and return to our receptionist.
Thank you!

Please Print
Patient Name: _____

Date of Birth: _____ / _____ / _____

Guarantor's Name if under 18 (if applicable): _____

Daytime Phone: _____

Email address: _____

Patient History Form

Name:_____ *Pronunciation* "_____" **Date:** _____/_____/_____

Address:_____ **Preferred Language:** English / Spanish **Birthday:** _____/_____/_____

City:_____ **State:** _____ **Zip:** _____ **Phone: ( ) _____ - _____**

Email: _____ **Communication Preference:** phone / email / text **Cell: ( ) _____ - _____**

How did you hear about us? _____ **Any Interest in Lasik Surgery? Yes / No Contact Lenses? Yes / No**

Year of your last Eye Exam? _____ **By which Eye Doctor? (If known)** _____ **Your Profession:**_____

---------- **Please check (✓) all that may apply to your medical history.** ----------

OCULAR
- O Blurred Vision (Dist / Near / Both)
- O Red Eyes
- O Itchy, Watery Eyes
- O Dry, Gritty Eyes
- O Eye Strain, headaches w/reading
- O Sensitivity to Light
- O Crusty Eyelids
- O Eyelid Bump or Swelling

ENDOCRINE
- O Diabetes *(Type 1 or Type 2)*
  For ____ Years Avg BSL:_____
- O Thyroid Disorder (Hyper / Hypo)
- O Hormonal Dysfunction
- O Pregnant Currently
- O Birth Control

CARDIOVASCULAR
- O Stroke / Aneurysm
- O High Blood Pressure *Avg BP* ____/____
- O Heart Problems
- O High Cholesterol

RESPIRATORY
- O Emphysema / COPD
- O Asthma / Shortness of Breath
- O Pneumonia
- O Coughing / Wheezing

NEUROLOGICAL
- O Headaches / Migraines
- O Epilepsy/Seizures
- O Multiple Sclerosis

(Vision and Health Symptoms for Yourself)
- O Double Vision
- O Eye Pain
- O Floaters / Spots
- O Flashes of Light
- O Glare and Halos
- O Waviness in Vision
- O Vision Loss (Side / Central / Temporary)

MUSCULOSKELETAL
- O Arthritis / Rheumatism / Osteoarthritis
- O Muscular Dystrophy
- O Spondylitis

CONSTITUTIONAL
- O Unexplained Weight Loss
- O Developmental Disability
- O Fatigue
- O Fever

SKIN
- O Rosacea
- O Psoriasis
- O Rashes / Shingles
- O Eczema

GENITOURINARY
- O Kidney Disease / Dialysis
- O STD / HSV /
- O Painful/Frequent Urination
- O Kidney Stones, Blood in Urine

CANCER
- O Type: _____ Year_____
- _____ Year_____

- O Loss of Color Vision
- O Cataracts
- O Retinal Detachment or Disease
- O Lazy Eye / Eye Turn
- O Glaucoma
- O Macular Degeneration
- O Eye Surgery or Injury: _____

PSYCHIATRIC
- O Depression
- O Anxiety
- O Panic Disorder

EAR, NOSE, THROAT
- O Hearing Loss
- O Sinus Congestion
- O Upper Respiratory Infection
- O Jaw Pain

GASTROINTESTINAL
- O Nausea/Vomiting
- O Ulcers, Heart Burn
- O Hepatitis
- O Colitis, Crohn's Disease, IBS

HEMATOLOGY/LYMPHATIC
- O Sickle Cell
- O Anemia
- O Lymphoma

ALLERGIES
- O Itchy, Watery Eyes from Allergies

List Allergies: _____

AUTOIMMUNE O HIV+ O Tuberculosis

(Required by Insurance)

Vitals & Social History: Height: _____ ft ____ in. Weight: _____ lbs Blood Pressure: _____ / _____ Pregnant? Y / N

Do you consume excessive alcohol? Yes / No Use illegal drugs? Yes / No Do you smoke? Yes (amt. per day_____) / No

Family History (Please check all that may apply and relationship)

O Diabetes _____ O Hypertension_____ O Heart Disease_____

O Glaucoma_____ O Macular Degeneration_____ O Blindness_____

Who is your Family Physician? _____ **Which Pharmacy do you use?** _____

Medications you are currently taking? _____

_____ **Medication Allergies**: _____

The doctor would like to dilate your eyes today, as it is one of **the most important aspects of the exam to determine the health of your eyes.** There is no extra charge for dilation. The side effects of dilation are increased sensitivity to light for 2-3 hours and possible reading difficulty for one hour. **Most people can drive with the use of sunglasses**, and if you do not have any with you, we can provide you with a pair of disposable sunglasses.

May the doctor dilate your eyes today? Y / N → IF NO, please sign to decline dilation: X_____

INSURANCE INFORMATION

*****<u>This only needs to be completed if you know that you have insurance that you want the doctor to file for.</u>*****

General Health Insurance does not pay for Routine Eye Exams. Even if you have vision insurance, the doctor may not be a provider for your plan. Please ask us if we are participating in your plan. All insurance information must be given to the receptionist before being seen. <u>You are responsible for knowing your policy and coverage.</u> Some insurance plans require prior authorization and we cannot go back and file once services have been rendered and you leave our office. If you would like to use an insurance plan to pay for the exam, please fill out completely, and sign below. Please keep your insurance card out as we may need to make a copy of it for our records. Thank you.

Name of Insurance: _____ or (see copy) Insured's Policy or Group #: _____
Patient's Name: _____ Date of Birth: _____/_____/_____
Social Security #:_____ Marital Status: Single / Married / Widow

Please fill out if you are **not** the primary policy holder i.e. you are insured under somebody else:
Name of Insured: _____
Your relationship to patient: O Spouse O Child O Other:_____
Social Security Number of Policy holder:_____
Insured's Date of Birth: _____ Insured's Telephone #: _____

Is there a secondary or supplemental insurance? Y / N
If Yes, then please fill out the following:
Name of Insurance:_____
Policy #:_____

Patient's or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I understand that if the physician is unable to collect payment due to my ineligibility of benefits, me not meeting my yearly deductible, or that if my eye care insurance carrier may pay less than the actual bill for services, that I agree that I am responsible for payment of all services rendered including collection costs on my behalf or my dependents, that he/she has the right to bill me for his/her services, which will be billed at full rate. I have read the disclosure above and agree:

X_____ Date:_____

***** MEDICARE PATIENTS *****

You need to make a choice about using Medicare to pay for today's health care service, as they may not pay. **Do expect that Medicare will <u>not</u> pay for all services, including the Refraction ($30), your Glasses, Contact Lens Fitting, Contacts and Routine Eye Examinations**. Medicare may pay if you have met your deductible for the year, and we happen to find a Medical Diagnosis or Ocular Disease in your eyes. Even then, there is no guarantee of payment, and you will be responsible for any fees billed that remain uncollected from Medicare and/or your secondary insurance. You are not eligible for the prompt pay discount rate once you ask us to file Medicare. Please let the Doctor know if you are under Hospice care. If you have any questions about this, please ask. If you **do** wish for us to file with Medicare, please sign below to acknowledge your understanding of our policy. I authorize The Eye Site of Bluffton to bill my Medicare and Secondary insurances:

X_____ Date:_____

Thank You and Welcome to Our Office!

HIPPA - RECEIPT OF NOTICE OF PRIVACY AND CONSENT FORM
By signing this form you are protecting your personal health information

The Eye Site of Bluffton
104 Buckwalter Parkway, Unit 1C
Bluffton, SC 29910
843-757-9588

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you,
to obtain payment for our services, and to conduct health care operations involving our office.
The Notice of Privacy Practices you have been or can be given to you describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form.
A framed copy is posted on the wall. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for the purposes of payment includes; (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers claims for review, determination of benefits and payments; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payments described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses and disclosures made for purposes of treatments, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from The Eye Site of Bluffton.

X _____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Parental/Gaurdian Name and Contact phone number if patient is under 18 (please print):
Name _____ Daytime Phone _____