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CLEAR VISION

## Patient information

Patient:

Name:_____ DOB:_____ City:_____

Mailing Address:_____ State:_____

Zip:_____ Home Phone:_____ Work:_____

Cell:_____ Email:_____

Primary Care Physician:_____

Emergency:

Contact:_____ Telephone:_____

## Responsible Party

(Please fill out this section if different than above)

Full Legal Name:_____ SSN:_____

Billing Address:_____ DOB:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

## Insurance Information

(Please present all insurance cards and photos i.d. to front desk upon arrival)

Policy Holder:_____

Primary Insurance:_____ Policy Number:_____

Secondary Insurance:_____ Policy Number:_____

Last Four SSN:_____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated for any services furnished to me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or these benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked. **I understand that I am financially responsible for all charges whether or not covered by my insurance company.**

I have read and understand the above statements.

_____ _____

Signature Date

## Medical Health History Questionnaire

### What is your preferred form of communication from our office

**Demographics:** Sex:_____ Ethnicity:_____ Preferred language:_____ Race:_____

Are you diabetic?_____ If yes, who is the primary care provider?_____

What was your last A1C?_____ When was it taken and where?_____

Have you had a pneumonia vaccination?_____ Do you use tobacco?_____

Frequency?_____

**Your chief complaint today:**_____

Onset?_____ Which eye?_____ Pain?_____ Duration?_____

**Have you had any eye surgeries?** If yes, Please List

| Date | Procedure | Surgeon | Eye |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Personal and Family Ocular History**

| Condition | Self: | Relation of Family member: | Condition: | Self: | Relation of Family member: |
|---|---|---|---|---|---|
| Diabetic Retinopathy | **Y / N** | | Blindness | **Y / N** | |
| Cataracts | **Y / N** | | Strabismus/amblyopia | **Y / N** | |
| Macular degeneration | **Y / N** | | Chronic Dry Eye | **Y / N** | |
| Glaucoma | **Y / N** | | Retinal Detachment | **Y / N** | |

## Review of Systems: (Conditions with your general health)

Your general health status?_____

Integumentary: (Skin problems)_____

Ears/Nose/Throat/Mouth_____

Respiratory: (COPD,Asthma)_____

CardioVascular: (Heart, Blood pressure, Stroke)_____

Gastrointestinal: (Digestion, Bowl)_____

Genitourinary tract: (Bladder)_____

Musculoskeletal: (Arthritis)_____

Neurological: (Seizure, Headache)_____

Endocrine: (Diabetes, Thyroid dysfunction)_____

Hermatologic: (Blood disorder)_____

Psychiatric: (Depression, ADD)_____

Allergies/Immunologic: (MS, Food or Drug allergies)_____

| Please List all Medications, Prescribed and Over the counter with Dosage |
| --- |
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# Designation of Personal Representative

## Amarillo I Care
## 3401 Soncy, suite 100
## Amarillo, Texas 79119

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to nomination that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

## Designation Section

I,_____(Print name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of the health information that pertains to me.

_____

(Print Name or Personal Representative)

The authority of this person when acting as my personal representative is restricted to the following functions:

This person is to be afforded all of the privileges that would be afforded to me with respect to my health information. **Y** / **N**

I understand that I may revoke the designation at any time by signing the revocation section of my copy of this form and returning it to Amarillo I Care, I further understand any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature Date

## Revocation Section

I hereby revoke this designation of a personal representative

_____ _____

Signature Date

**I acknowledge that I have received or been given the opportunity to read the Privacy Notice.**

**I acknowledge my eye care professional will provide me with a copy of my prescription at the completion of my Exam.**

_____ _____

Patient or Personal Representative signature Date

**If patient's personal representative signature appears above, please describe personal representative's relationship to the patient:**

_____

_____

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