CROSSROADS FAMILY EYECARE – INFORMATION FORM

Name: _____ Date: _____

Address: _____ City: _____

Zip Code: _____ Date of Birth:___/___/_____ SS#: _____

Home Phone: _____ Cell: _____

Email: _____

Name of Insurance Policy Holder: (If other than patient) _____

Policy Holder DOB: _____ Policy Holder SS#:_____

Review of Systems: *(please circle all that apply)*

1. Constitution – Developmental Disabilities, Cancer, Fatigue Syndrome, Other: _____
2. Ear/Nose/Throat – Hearing Loss, Sinus Problems, Dry Mouth, Laryngitis, Other: _____
3. Neurological – MS, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraine, Other: _____
4. Psychiatric -- Depression, ADD, Anxiety Disorder, Bipolar Disorder, Other: _____
5. Cardiovascular – High Blood Pressure, Heart Disease, Vascular Disease, Congestive Heart Failure, Heart Attack, Other:_____
6. Respiratory – Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea, Other: _____
7. Gastro Intestinal – Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other: _____
8. Genitourinary – Kidney Disease, Prostate Disease, Prostate Cancer, STD, Benign Prostate Hypertrophy, Pregnant/Nursing, Other: _____
9. Muscular/Skeletal – Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout, Other: _____
10. Dermatologic – Eczema, Rosacea, Psoriasis, Herpes Simplex (cold sore), Herpes Zoster (shingles), Other: _____
11. Endocrinology – Type 2 Diabetes, Type 1 Diabetes, Thyroid Dysfunction, Hormonal Dysfunction, Other: _____
12. Hematological/Lymphatic – Anemia, Large Volume Blood Loss, Ulcer, High Cholesterol, Other: _____
13. Allery/Immunologic – Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, Other: _____

Medications and Usage: (dosages as well) Example: Lisinopril = High Blood Pressure

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Drug Allergies:

_____ _____ _____

Please list previous ocular conditions: (ex. Cataract Surgery) _____

Do you wear glasses? _____ yes _____ no ***Eye Color:*** _____

Do you wear contacts? _____ yes _____ no If so, please list brand & powers: _____

Social History: Do you drink alcohol? _____ yes _____ no If yes, how often? _____

Do you smoke? _____ yes _____ no If yes, how often? _____

Hobbies: _____

Primary Care Physician: _____ Phone: _____
Pharmacy Name and Location: _____

Family Medical History: (please circle all that apply)

Cancer Father Mother Brother Sister Son Daughter Other: _____

Diabetes Type 1 Father Mother Brother Sister Son Daughter Other: _____

Diabetes Type 2 Father Mother Brother Sister Son Daughter Other: _____

Hypertension Father Mother Brother Sister Son Daughter Other: _____

Hyperthyroidism Father Mother Brother Sister Son Daughter Other: _____

Hypothyroidism Father Mother Brother Sister Son Daughter Other: _____

Family Ocular History: (please circle all that apply)

Cataract Father Mother Brother Sister Son Daughter Other: _____

Macular Degeneration Father Mother Brother Sister Son Daughter Other: _____

Glaucoma Father Mother Brother Sister Son Daughter Other: _____

How did you hear about us?

Friend or Family Who: _____ Website Facebook

PROCEDURES MAY BE INDICATED AND DISCUSSED THAT EXCEED THE MINIMUM THAT IS APPROVED BY INSURANCE.(PLEASE CHECK IF INSURED)
____ I DO authorize those services today. I want complete and optimal eye care even if I incur out of pocket costs.
____ I DO NOT authorize those services today. I do not want extra out of pocket costs, so limit my care to what should be covered.

I authorize and consent to the examination and treatment of the above patient. I certify that the above information is correct. I authorize the doctor to release any information needed to process my insurance claims and I assign payment to the provider to any benefits. I am responsible for fees incurred and any additional cost of collection, including reasonable attorney's fees and interest at 2% per month on any unpaid balance on this account and I agree to promptly pay amounts due when incurred or upon insurance denial.

_____ _____

Patient Signature Date

Crossroads Family Eyecare HIPAA Notice of Privacy Practices

Effective 01/01/2017

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I hereby give my consent for Crossroads Family Eyecare to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
- I allow the electronic transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by Crossroads Family Eyecare.
- I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
- I may revoke my consent in writing except to the extent that Crossroads Family Eyecare has already made disclosures in reliance upon my consent- If I do not sign this consent or later revoke it, Crossroads Family Eyecare may decline to provide treatment to me.
- I further authorize and request that insurance payments be made directly to Crossroads Family Eyecare should they elect to receive such payment.
- I have received and or read a copy Crossroads Family Eyecare's Notice of privacy practices that tells me my rights and how Crossroads Family Eyecare will use and disclose my protected health information.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

_____

Patient Name

_____ _____

Signature of Patient or Legal Guardian Date