

Oak Hill Eye Care Patient Health History

Patient Name: _____ Gender: _____ Birth Date: _____

SS#: _____ Primary Care Physician: _____

Address: _____ City & State: _____ Zip Code: _____

Phone Home: _____ Work: _____ Cell: _____ Preferred Contact Number: _____

E-mail Address: _____ Occupation/Employer: _____

Emergency Contact Name/Phone Number: _____ Relation to You: _____

How did you hear about our office? _____

Do you have vision insurance? No Yes If yes, Insurance Carrier: _____

Do you have health insurance? No Yes If yes, Insurance Carrier: _____

Do you have Medicare? No Yes

OCULAR HISTORY

Current vision correction: Glasses Contact Lenses None

Currently experiencing difficulty with: Distance Vision No Yes Near Vision No Yes

Please list prescription and non-prescription medication you are currently using *for your eyes*: _____

Have you ever had eye surgery? No Yes

If yes, please indicate: Right Eye Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Left Eye Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Have you ever had eye injury? No Yes If yes, please describe: _____

Do you currently have any of the following symptoms?

Eye pain No Yes

Blurry vision No Yes

Double vision No Yes

Flashes of light No Yes

Floaters No Yes

Light sensitivity No Yes

Glare/halos No Yes

Redness No Yes

Itching No Yes

Burning No Yes

Dryness No Yes

Foreign body sensation No Yes

Gritty sensation No Yes

Other: _____

Have you been diagnosed with any of the following conditions?

Glaucoma No Yes

Macular degeneration No Yes

Cataracts No Yes

Retinal tear/detachment No Yes

Lazy eye (amblyopia) No Yes

Dry eye syndrome No Yes

Ocular allergies No Yes

Other: _____

Has anyone in your family been diagnosed with any of the following conditions? If yes, please indicate relation.

Glaucoma No Yes: _____ Relation

Macular degeneration No Yes: _____

Retinal detachment No Yes: _____

MEDICAL HISTORY

Have you been diagnosed with any of the following conditions?

High Blood Pressure No Yes

Heart Disease No Yes

High Cholesterol No Yes

Stroke No Yes

Diabetes No Yes

Arthritis No Yes

Please list any other medical conditions: _____

Please continue on other side.

MEDICAL HISTORY CONTINUED

Have you ever been hospitalized or had surgery? No Yes If yes, please explain: _____

Please list any medications you take, prescription and non-prescription. Include dosages if possible: _____

Are you allergic to any medications? No Yes If yes, please list: _____

Are you currently pregnant? No Yes Nursing? No Yes

Review of Systems

Are you currently experiencing problems with any of the following? If yes, please explain.

- Sudden weight gain or loss No Yes: _____
- Chronic fever or chronic fatigue No Yes: _____
- Heart (chest pain, irregular heart beat) No Yes: _____
- Respiratory (coughing, shortness of breath, asthma) No Yes: _____
- Ear/Nose/Throat (sinus problems, hearing loss, sore throat, ear ache) No Yes: _____
- Gastrointestinal (abdominal pain, heart burn, bowel problems) No Yes: _____
- Hematologic/Lymphatic (blood disorders, enlarged glands) No Yes: _____
- Endocrine (thyroid, diabetes) No Yes: _____
- Integumentary (rashes, dry skin) No Yes: _____
- Musculoskeletal (joint or muscle pain, weakness, bone loss) No Yes: _____
- Neurological (headache, migraines, seizures, paralysis) No Yes: _____
- Psychiatric (depression, anxiety, ADD/ADHD, insomnia) No Yes: _____
- Allergic (reaction to food or drugs, seasonal allergies) No Yes: _____
- Immunologic (rheumatoid arthritis, lupus, multiple sclerosis) No Yes: _____

FAMILY MEDICAL HISTORY

Has anyone in your family been diagnosed with any of the following conditions? If yes, please indicate relation.

- | | | | |
|---------------------|---|---------------|---|
| | Relation | | Relation |
| High Blood Pressure | <input type="radio"/> No <input type="radio"/> Yes: _____ | Heart Disease | <input type="radio"/> No <input type="radio"/> Yes: _____ |
| High Cholesterol | <input type="radio"/> No <input type="radio"/> Yes: _____ | Stroke | <input type="radio"/> No <input type="radio"/> Yes: _____ |
| Diabetes | <input type="radio"/> No <input type="radio"/> Yes: _____ | Arthritis | <input type="radio"/> No <input type="radio"/> Yes: _____ |
| Other: _____ | | | |

SOCIAL HISTORY

- Use of Alcohol: Never Rarely Moderately Daily: _____ drinks/day
- Use of Tobacco: Never Previously, but not in past _____ years Yes: _____ packs/day

To the best of my knowledge, I completed this form accurately. I understand that it is my responsibility to inform my doctor of any changes in my health/medical status.

Signature of Patient (or Guardian) Date: _____

****TO BE COMPLETED BY CONTACT LENS PATIENTS ONLY****

Oak Hill Eye Care Annual Contact Lens Agreement

Please review the following points regarding your contact lens care and sign below to indicate that you read and understand the terms of the agreement.

- The fitting and/or evaluation of contact lenses is performed *in addition to* a general eye exam. The fee for this service varies based on the type of contact lenses prescribed by your doctor. **This fee may not be covered by your insurance. If you have any question about your insurance benefits, please ask prior to your exam.**
- Because contact lenses are medical devices, Texas law requires an annual contact lens evaluation in order to renew your contact lens prescription. This applies even if there is no change in prescription. More frequent evaluations may be needed for patients with certain ocular conditions.
- It is important to wear sunglasses over your contact lenses because UV light causes cataracts, macular degeneration and pingueculae (tissue growth on the white part of the eye). Please ask one of our opticians about specials on non-prescription sunglasses for contact lens wearers.
- Back-up glasses in the correct prescription are needed in case of infection and so that you are able to take regular breaks from contacts lens wear. Please ask one of our opticians about specials on back-up glasses for contact lens wearers.
- Contact lenses may be returned for credit within 30 days of original purchase. **Boxes of contact lenses must be re-sellable (unopened and free of markings) in order to receive credit.**
- Because many contact lenses are not kept in stock and sometimes even trial lenses need to be ordered, it is best not to wait until you are completely out of lenses to re-order or make an appointment with us.
- There is an increased risk of infection or corneal ulcers that can cause vision loss with contact lens wear. This risk increases if contacts are worn overnight.
- While some contacts are approved for extended/overnight wear, always discuss this option with your doctor before sleeping with your lenses in. Not all patients are good candidates for this wear schedule and not all contacts are FDA-approved for overnight wear.
- If you purchase an annual supply of contacts, we will ship them to you at no charge. If you order less than a one year supply and wish to have your contacts delivered to your home, you will be responsible for any shipping fees.
- Payment for contact lenses is due at the time of order.

Signature

Date

Optomap® Retinal Imaging

Our doctors want *all* patients to have Optomap® retinal imaging performed each year. A comprehensive eye exam includes a thorough retinal evaluation. Optomap® retinal imaging will be done annually unless a waiver is signed. The fee is **only \$28**. This is *significantly* less than the fees charged by other offices in the area. It is not covered by insurance.

This state-of-the-art scanning digital technology enables your doctor to examine your retina without dilating your pupils. A thorough examination allows for early detection of glaucoma, macular degeneration, diabetic retinopathy, hypertension and ocular melanoma. These conditions typically have no associated symptoms.

Advantages of Optomap® retinal imaging:

- An ultra-wide view of your retina that your doctor will review with you
- Does not require pupil dilation so you can resume normal activities immediately (Dilation causes blurry vision and light sensitivity for 6 to 8 hours.)
- Provides permanent records for future comparison
- Quick, comfortable, non-invasive and completely safe
- Decreases the amount of time spent waiting in the office

Please indicate your preference:

_____ I prefer to have the Optomap®.

_____ I decline both the Optomap® *and* dilation.

_____ I prefer to have my pupils dilated.

_____ I would like to discuss this further with my doctor.

I have read and understand the above explanation of Optomap® retinal imaging. I acknowledge that there is an additional fee for this service that is not covered by insurance.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Oak Hill Eye Care Patient Policy

To ensure understanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our front office staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential part of your care.

Your Insurance

As a courtesy to you, we will submit the billing for today's services to your insurance carrier. Any balance not paid by your insurance carrier is your responsibility and you will receive a statement for payment. Unless other arrangements are made in advance, full payment is due at the time of service. For your convenience, we accept MasterCard, Visa and Discover. Copayments will be collected at the time of your appointment.

In the event that your insurance plan determines a service to be "not covered," you will be responsible for the full payment.

It is your responsibility to know whether or not you have met your deductible for the current year.

If we do not have a contract with your insurance carrier, we will be happy to prepare a claim for you to file. Charges for services will be due at the time of service and your insurer will send the payment directly to you.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient or the parent/guardian for payment.

Contact Lens Patients

Please be aware that the fitting or evaluation of contact lenses is performed in addition to your eye exam and there is a separate fee for this service. The fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. **It may not be covered by insurance.**

Optomap Retinal Imaging

Our doctors want **all** patients to have Optomap® retinal imaging. This allows them to examine the retina without pupil dilation. Optomap® retinal imaging will be done annually unless a waiver is signed. The fee is **only \$28**. It is not covered by insurance.

Release of Information

Oak Hill Eye Care may release information to your insurance carrier for claims processing purposes only. Insurance claim information is transmitted via secure internet connection. Oak Hill Eye Care may also send you mail correspondence, such as recall notices.

I have read, understand and agree to the terms of the policy of the practice. I also understand that the policy may be amended as needed.

Printed Name of Patient: _____ Date: _____

Signature of Patient (or Responsible Party): _____

Notice of Privacy Practices

I understand that the privacy practices of Oak Hill Eye Care are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I may view and/or print a copy of this Act at my convenience by visiting www.oakhill eyecare.com. I also understand that I may request a copy of this Act from the front office staff.

Printed Name of Patient: _____ Date: _____

Signature of Patient (or Responsible Party): _____

Name _____

Date: _____

Due to new quality reporting guidelines mandated by the government to improve continuity of care, we are required to ask the following questions:

Preferred language:

- English
- Spanish
- Other _____

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Declined
- Other _____

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Height:

_____ ft _____ in

Weight:

_____ lbs