Welcome to our Office....

Thank you for choosing our practice for your eyecare needs. Please fill out the following information. You will not be asked to fill out this same information on subsequent visits. If you have questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient name ______________________________ Date of birth ____________________

Address ______________________ City ____________ State ______ ZIP Code _______

Home phone ___________________________ Other phone _______________________

Social Security Number __________________ Email Address ____________________

Whom may we thank for referring you to us? ____________________________________

Method of Payment
( ) Cash/Check ( ) Medicare
( ) Medicaid ( ) VSP
( ) Insurance _______________________________

Many insurances request that we have your signature on file to bill for vision benefits. Please read the following paragraph and sign below so that we will bill your vision insurance.

Note: Even if you do not currently have vision insurance, please go ahead and sign below so that we have your signature on file should you have insurance in the future.

I request that payment of authorized benefits be made either to myself or on my behalf to Brian D. McCollom, O.D. for any services furnished me by Dr. McCollom. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9of the HCFA – 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, or-insurance, and noncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_______________________________ ____________________

Signature Date

Name________________________________ Date__________________________

Personal Medical History (ROS)

* **Constitutional**
  - [Y/N] Developmental Disabilities
  - [Y/N] Cancer
  - [Y/N] Fatigue Syndrome
  - [Y/N] Other

* **Ears, Nose, Throat, Mouth**
  - [Y/N] Hearing Loss
  - [Y/N] Sinusitis
  - [Y/N] Dry Mouth
  - [Y/N] Laryngitis

* **Neurological**
  - [Y/N] Multiple Sclerosis
  - [Y/N] Epilepsy
  - [Y/N] Cerebral Palsy
  - [Y/N] Migraine

* **Psychiatric**
  - [Y/N] Depression
  - [Y/N] Attention Deficit
  - [Y/N] Anxiety
  - [Y/N] Bipolar

* **Cardiovascular**
  - [Y/N] Hypertension
  - [Y/N] Stroke/CVA
  - [Y/N] Heart Disease
  - [Y/N] Vascular Disease
  - [Y/N] Congestive Heart Failure

* **Respiratory**
  - [Y/N] Asthma
  - [Y/N] Bronchitis
  - [Y/N] Emphysema
  - [Y/N] COPD
  - [Y/N] Sleep Apnea

* **Gastrointestinal**
  - [Y/N] Crohn's
  - [Y/N] Colitis
  - [Y/N] Ulcer
  - [Y/N] Acid Reflux/Heart Burn
  - [Y/N] Celiac Disease

* **Genitourinary**
  - [Y/N] Kidney Disease
  - [Y/N] Prostate Disease/Cancer
  - [Y/N] STD
  - [Y/N] Benign Prostate Hypertrophy
  - [Y/N] Pregnant
  - [Y/N] Nursing

* **Musculoskeletal**
  - [Y/N] Arthritis
  - [Y/N] Osteoarthritis
  - [Y/N] Fibromyalgia
  - [Y/N] Muscular Dystrophy
  - [Y/N] Osteoporosis
  - [Y/N] Gout

* **Integumentary**
  - [Y/N] Eczema
  - [Y/N] Rosacea
  - [Y/N] Psoriasis
  - [Y/N] Herpes Simplex/Cold Sores
  - [Y/N] Herpes Zoster/Shingles

* **Endocrine**
  - [Y/N] Type 2 Diabetes
  - [Y/N] Type 1 Diabetes
  - [Y/N] Thyroid Dysfunction
  - [Y/N] Hormonal Dysfunction

* **Hematologic/Lymphatic**
  - [Y/N] Anemia
  - [Y/N] Hypercholesteremia

* **Allergic/Immunologic**
  - [Y/N] Drug Allergies
  - [Y/N] Environmental Allergies
  - [Y/N] Rheumatoid Arthritis
  - [Y/N] Lupus
  - [Y/N] Sjogren's Syndrome

Please list any medications you are currently using:
Medication/Dosage/Frequency

____

____

____

____

____

Are you allergic to any medications? [Y/N] If yes, which medications?

____

Past Ocular History

When was your last eye exam?____________________ Dr. name?____________________

Do you currently wear glasses [Y/N] or contacts [Y/N]? If so, what type?____________________

____

Please check if you have any of the following:

[ ] Glaucoma [ ] Glaucoma Suspect [ ] Cataracts [ ] Surgery [ ] Macular Degeneration

[ ] Strabismus [ ] Amblyopia [ ] Retinal Degeneration/Hole Detachment [ ] Keratoconus

[ ] Dry Eye [ ] Nystagmus

Immediate Family Medical History: Please Answer Who Has It

[ ] Hypertension________________ [ ] Diabetes________________ [ ] Cancer ______________

[ ] Glaucoma ______________ [ ] Cataracts __________ [ ] Macular Degeneration ____________

Social History

Do you:

[Y/N] Smoke

[Y/N] Drink

[Y/N] Smokeless Tobacco

Personal History

Occupation____________________

Hobbies____________________

Hours/day computer use____________

NOTICE OF PRIVACY PRACTICES

This notice of privacy practices describes how we may use or disclose your health information and how you can get access to such information. A full copy of our privacy practices is available upon request.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Brian D. McCollom, O.D. Notice of Privacy Practices.

Date ____________ Patient Name__________________________ Signature______________________________