FORRESTER EYE ASSOCIATES

PHONE: (864) 642-1889
3320 N Main Street Anderson, SC 29621

Welcome to Our Office

Today's Date _____
Name _____
Street _____
City _____ State _____ Zip _____
Primary Phone _____
Secondary Phone _____
Employer/School _____
Occupation/Grade _____
Social Security Number _____
Date of Birth _____ Age _____ Sex ☐ Male ☐ Female
Email Address _____
Who may we thank for referring you to our office?
Name of Friend/Relative _____
If not referred, how did you choose our office?
☐ Another Doctor ☐ Insurance List
☐ Saw Sign/Building ☐ Internet Search

INSURANCE INFORMATION

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Member ID _____
Subscriber Birth Date _____

PRIMARY CARE INFORMATION

Name of Family Physician _____
Office Phone Number _____
Date of Last Physical Exam _____

PATIENT AND FAMILY HEALTH HISTORY

Please notate whether relation is maternal/paternal.

Blindness	☐ Self	☐ Relation _____
Cataracts	☐ Self	☐ Relation _____
Corneal Abrasion	☐ Self	☐ Relation _____
Corneal Transplant	☐ Self	☐ Relation _____
Diabetes	☐ Self	☐ Relation _____
Eye Infection	☐ Self	☐ Relation _____
Eye Injury	☐ Self	☐ Relation _____
Glaucoma	☐ Self	☐ Relation _____
Heart Disease	☐ Self	☐ Relation _____
Iritis/Uveitis	☐ Self	☐ Relation _____
Lazy Eye	☐ Self	☐ Relation _____
Macular Degeneration	☐ Self	☐ Relation _____
Retinal Detachment	☐ Self	☐ Relation _____

PATIENT MEDICAL HISTORY

List Current Medications (prescriptions and/or over the counter—including eye drops, vitamins, birth control, etc.)

_____
_____
_____

Allergies to Medications? ☐ No ☐ Yes
What kind? _____
Do you smoke? ☐ No ☐ Yes
Do you drink? ☐ No ☐ Yes
How many drinks per week? _____
Do you use illegal drugs? ☐ No ☐ Yes
What kind? _____
Have you been diagnosed with the following diseases?:

☐ Allergies ☐ Asthma ☐ Arthritis
☐ Cancer ☐ Cholesterol ☐ Diabetes
☐ Heart Disease ☐ High Blood Pressure ☐ Kidney
☐ Nerves ☐ Thyroid
☐ Other _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____
By Whom? _____
Do you currently wear contact lenses? ☐ No ☐ Yes
What Kind? _____
Solutions Used? _____
Any Problems? _____
Interested in a new contact lens design? ☐ No ☐ Yes
Do you currently wear glasses? ☐ No ☐ Yes
Any Problems? _____

Do you currently experience…

☐ Blurry Vision ☐ Burning ☐ Crossed Eye
☐ Double Vision ☐ Dryness ☐ Flashes of Light
☐ Floaters/Spots ☐ Grittiness ☐ Headaches
☐ Itchiness ☐ Sunlight Sensitivity
☐ Tearing ☐ Trouble Seeing at Night

Please complete the following statements:

I work on a ☐ laptop / ☐ desktop _____ hours a day.
I spend _____ hours a week outdoors.
I have prescription sunglasses. ☐ No ☐ Yes
I prefer to not wear my glasses at times. ☐ No ☐ Yes
I have children. ☐ No ☐ Yes
My hobbies/interests are _____
_____

FORRESTER
EYE ASSOCIATES

HIPAA— Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Forrester Eye Associates may use or disclose your health care information. The notice also explains the rights that you are guaranteed under HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice.

Forrester Eye Associates has always taken great care to protect the integrity and confidentiality of your health care information; we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer listed: *Amber Bilbrey, Compliance Office*

I hereby acknowledge that I have received a copy of the Forrester Eye Associates Notice of Privacy Practice.

Name: _____ Date of Birth: ____ / ____ / _____

Signature: _____ Today's Date: ____ / ____ / _____

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to:

Name: _____

Relationship: _____

Permission to Bill Your Insurance

Be aware that your insurance is a contract between you and your insurance company. We will submit a claim to your insurance company; however, if your insurance company has not paid us within 45 days, the balance is your responsibility. After three statements, your account may be sent to an outside collection agency.

I have read, understand, and agree to the insurance assignment and financial policies stated above.

Signature of Patient or Guarantor: _____

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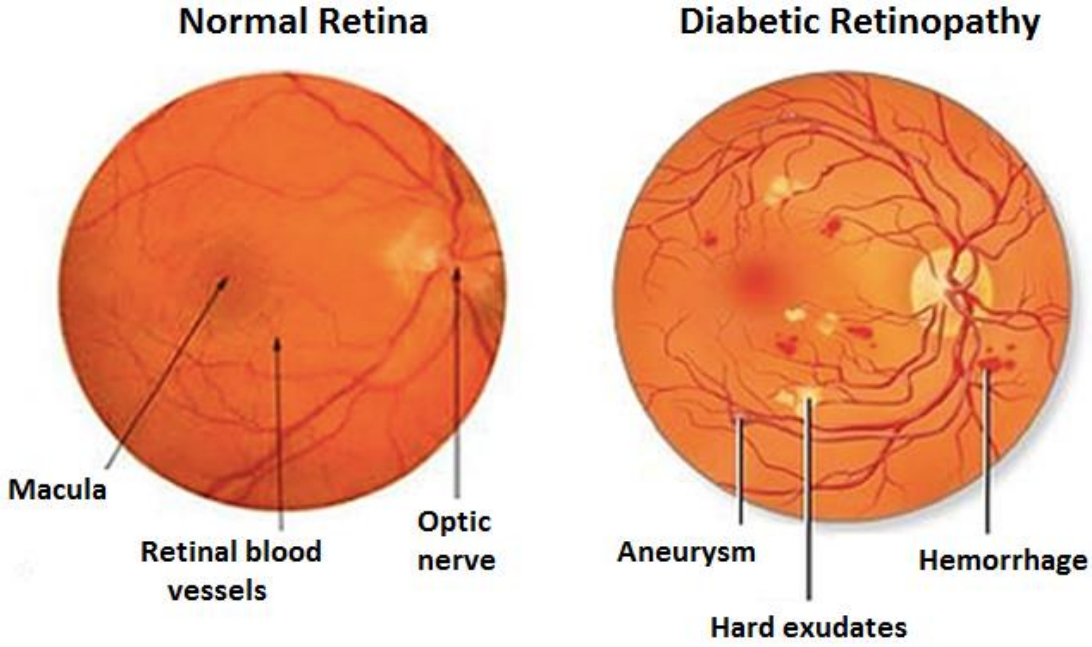
3320 North Main Street Anderson, SC
Phone: (864) 642-1889
www.forrestereye.com

Retinal Imaging and Dilation Consent Form

As part of your eye exam, we recommend a special diagnostic procedure called Retinal Photography. In this procedure a Retinal Camera is used to take a photograph of the back of the eye (the retina). This is not an X-ray or an ultrasound, nothing will touch your eye, it is simply a highly magnified photograph. Also, with Retinal Photography you may not need to be dilated.

This permanent digital record is very valuable in assessing the health of your eyes presently and in monitoring the health of your eyes over the years. We are able to observe the retina, optic nerve, macula, and blood vessels and arteries of the eyes. It will also serve as an initial reference point with which to compare any changes as we monitor your health in subsequent years.

The fee for this additional part of your eye exam is **$38** which will be charged every year that photos are taken. Depending on your diagnosis, if there is a medical issue such as diabetes, glaucoma, etc., this procedure may be covered under your medical insurance. Retinal Photography is not covered under most vision plans such as VSP, EyeMed or Davis Vision. This office will advise you of your coverage.



Retinal Photography

_____ Yes, I want to have retinal photos taken of my eye for documentation.

_____ No, I do not wish to have retinal photos taken.

Dilation

_____ Yes, I do want to be dilated. *Last time you were dilated? _____

_____ No,I do not want to be dilated. ***In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.***

Patient Signature _____ Print Name _____

Date _____