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| **Demographics** |
| Full Name: Birth Date: Age: Sex: Male FemaleAddress: City: State: Zip Code:Cell Phone: Home Phone: Other Phone: Email: Employer/School: Occupation: How did you hear about us? Friend/Family Social Media Internet Radio Other: |
| **Parent/Guardian Information for Minors** |
| Parent:Employer: Occupation: Phone Number: Email: | Parent:Employer: Occupation: Phone Number: Email: |
| **Insurance Information** |
| Insurance Company: Primary Insurance Holder Name:  | Policy Number: Birth Date: Last Four Digits of Social Security Number:  |
| **Medical & Eye Health History** |
| Main reason for examination today:Date of last exam: Doctor’s name: Reason for examination:Have you ever worn contact lenses? Are you interested in Laser Vision Correction? | List any *current* medications: List any *current* allergies and medication allergies:List all eye surgeries or injuries:List previous significant illnesses or surgeries:  |
| Have you been diagnosed with any of the following eye conditions? *(check all that apply)* Blindness Corneal Dystrophy Eye/Eyelid Cancer Thyroid Eye Disease Macular Degeneration Dry Eye Syndrome Retinal Detachment Implant Lens Hypertensive/Retinal DiseaseGlaucoma Diabetic Retinal Disease Other:Amblyopia/Lazy Eyes *\*(If yes, complete strabismus/amblyopia section)\**Strabismus/Wandering Eye/Eye Turns In or Out*\*(If yes, complete strabismus/amblyopia section)\** |
| Check any of the following symptoms you experience:Eye Pain/Burn/Itching Flashes of Light Change in Distance/Near VisionLight Sensitivity Headache New Spots or FloatersFluctuating/Blurred Vision Frequent Styes Excess TearingDouble Vision Mucus Discharge or Crusted Lids Loss of Side VisionDryness or Burning in Eyes *\*(If yes, complete dry eyes section)\** Sandy or Gritty Feeling *\*(If yes, complete dry eyes sensitivity section)\**Eye Strain with Reading or Computer Work *\*(If yes, complete reading/computer section)\**Dizziness or Car Sickness *\*(If yes, complete dizziness/motion sensitivity section)\** |
| **Medical Conditions** |
| Do you have the following conditions now or in the past?*Check any disease or condition that applies:*Allergies/Hay fever Arthritis BlindnessBrain Injury \*(If yes, complete brain injury section) Cancer Developmental Delay Diabetes Drug Sensitivity Ear/Nose/Throat Problems Gastrointestinal Heart Problem/Disease High Blood Pressure High Cholesterol Kidney, Bladder Lazy Eye/Amblyopia Lupus Migraine or Headaches Neurological (MS, seizures) Psychiatric (Depression, etc.) Respiratory (Asthma, etc.) Rheumatoid ArthritisSkin (Acne, cancer, etc.) Stroke Thyroid Other: Date of last physical exam: How was your general health? Excellent Good Fair Poor |
| **Insurance Signature on File** |
| I certify that the information given by me for insurance and/or Medicare/Medicaid payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or vision/medical benefits, and I authorize payment of these benefits directly to **Randall Cummings, O.D.** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above. **I have read, understood, and agree to billing terms and conditions.****Signature: Date:**  |

Patient Name: \***\*Skip sections that do not apply\*\***

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| **Visual History** |
| Do you report/experience any of the following?Nausea when doing visual tasks Closing or covering one eye Lose attention easilyPoor motor control (clumsiness) ADD/ADHD Eyelid DroopPoor reading comprehension Eyes frequently reddened Lose place while readingLearning Disorders DyslexiaWhen reading, letters/words appear to move or float around Rubbing eyes excessively *\*(If yes, complete dry eyes sensitivity section)\**Eyes “hurt” or “tired” *\*(If yes, complete dry eyes sensitivity section)\**  Do you have any other concerns/observations/complaints concerning you or your child’s vision?  |
| **Strabismus/Amblyopia***(For children and adults with a lazy eye, eye turn, or crossed or wandering eye)* |
| * At what age was the eye turn first noticed?
* Did it start suddenly or gradually?
* Which direction does the eye turn*? (check all that apply)* Up Down Out In
* Which eye turns? Right Left Both
* Is the eye turn getting worse, better, or no change?
* When does the eye turn (always, what % of time, when tired, when ill, etc.)?
* Does the eye turn more when looking: Up To the right Up close Down To the left In the distance
* Do you ever notice one or both eyes shaking rapidly?
* If patching treatment was prescribed, please describe at what age patching was started, how it was done, the eye patched, for how long, and an estimate of the results.
* Has there been any surgery?
* If yes, estimate the results:
* Please describe any visual therapy, including duration of treatment, age at which it was started and estimate the results:
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| **Dry Eyes** |
| Over the past week, which of the following eye symptoms have you experienced? *(Check all that apply)* Glare Eye Ache Eyelids swollen or red along the lash margin Redness Burning Mattering on your eyelids when you wake up in the morning Tearing/Watery Eyes Dryness Decreased contact lens wearing Stinging Itching Light Sensitivity Night Driving Problems Grittiness Burning in the morning |
|  **Reading/Computer** |
| When reading, using a computer, or doing close work*, please check the following statements that apply to you:** My eyes feel tired
* I get headaches
* I feel sleepy
* I lose concentration
* I have trouble remembering what I read
* I get double vision
* Words move, jump, swim, or appear to float on a page/screen
* I read slowly
* My eyes hurt
* I feel a “pulling” feeling around my eyes
* Words blur or go in and out of focus
* I lose my place
* I have to reread the same line of words/sentences

*In addition, check all that apply:*Reverses or forgets letters, numbers or words Poor spellingTendency to close or cover one eye Poor reading comprehensionPoor visual-motor (eye-hand/foot) coordination Confuses right and leftDifficulty tracking moving objects, balls, etc. Writing is crooked or poorly spacedDifficulty recognizing the same word in the next paragraph Head tilt or movementHead too close to the paper while reading or writing Confuses similar looking wordsDifficulty following a sequence of directions Whispers when reading silentlyMisalignment of digits or columns of numbers Comprehension decreases over timeErrors copying from chalkboard, computer or book Avoids near work or readingDifficulty completing assignments in allotted time Does not visualize |
| **Dizziness & Motion Sensitivity** |
| Check all of the symptoms that are significant for you:Nausea, headache or dizziness when reading in a carNausea, headache or dizziness from 3-D movies or rapid camera movements in video games or moviesHyper-sensitivity to light (store lights seem bright, tend to wear sunglasses even on cloudy days)Flickering lights bother you (light through trees when driving or fluorescents)Frequent, sometimes daily headache or “pressure” in your headAvoidance of driving because of car sickness |

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| **Brain Injury***(Stroke, Head Injury, Concussion, Whiplash, Motor Vehicle Accident, Bike Accident, Brain Surgery, etc.)* |
| Date of most recent event:Briefly describe the injury: What part of the head was affected: Face Top of head Back of head Left side Right side Forehead Was there loss of consciousness? For how long? When did you first see a doctor regarding your accident/injury?Were you hospitalized? Describe any *previous* injuries and dates: |
| What types of professional care have you received or are receiving due to this injury?*(List care such as neurological, psychological, occupational therapy, physical therapy, speech, auditory, chiropractic, osteopathic, acupuncture, neurofeedback, etc.)*What is your most significant visual concern at this time? |
| *Brain Injury Vision Symptom Survey: (Please check the following questions that apply to you)*Eyesight Clarity Dry Eyes* Distance vision blurred and not clear—even with lenses Eyes feel “dry” and sting
* Near vision blurred and not clear—even with lenses “Stare” into space without blinking
* Clarity of vision changes or fluctuates during the day Have to rub the eyes a lot
* Poor night vision/cannot see well to drive at night

Reading Doubling* Short attention span/easily distracted when reading Double vision—especially when tired
* Poor reading comprehension/cannot remember what was read Have to close or cover one eye to see clearly
* Confusion of words/skip words when reading Words move in & out of focus when reading
* Difficulty/slowness with reading and writing
* Lose place/have to use finger to not lose place while reading

Light Sensitivity Depth Perception* Normal indoor lighting is uncomfortable Clumsiness/misjudge where objects really are
* Outdoor light too bright—have to use sunglasses Lack of confidence walking/stumbling
* Indoor fluorescent light is bothersome or annoying Poor handwriting (spacing, size, legibility)

 Visual Comfort * Eye discomfort/sore eyes/eyestrain Peripheral Vision
* Headaches or dizziness after using eyes Side vision distorted/objects move or change position
* Eye fatigue/very tired after using eyes all day What looks straight ahead—isn’t always straight ahead
* Feel “pulling” around eyes Avoid crowds/cannot tolerate “visually busy” places
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**NOTICE OF PRIVACY PRACTICES & CONSENT FORM**

Patient Name:

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The *Notice of Privacy Practices & Consent Form* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices & Consent Form*, the use and disclosures of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information to a billing agent or vendor for purposes of payment include:

1. Our submission of your health care information to a billing agent or vendor for processing claims or obtaining payment
2. Our submission of claims to third party payers or insurers for claim review, determination of benefits and payment
3. Our submission of your health information to auditors hired by third-party payers and insurers
4. Other aspects of payment desired in our *Notice of Privacy Practices & Consent Form*

Our *Notice of Privacy Practices & Consent Form* will be updated whenever our privacy practices change. You are able to obtain an updated copy at our office.

When you sign this consent document, you signify you agree that we have permission to use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations.

You have the right to ask our office to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices & Consent Form*, we are not obligated to agree to these suggested restrictions. If we do agree however, the restrictions are binding to us.

I have read, understood, and agree to the *Notice of Privacy Practices & Consent Form* provided by North Idaho Vision. I consent to the use and disclosure of my health information for purposes of treatment, payment, healthcare operations, and reoccuring visits.

Signature: Date: