North Idaho Vision

Randall Cummings, O.D.
1420 S. Blaine St. Suite 6 Moscow, ID 83843
Phone: (208) 882-2020 Fax: (208)892-2015 www.northidahovision.com

Demographics

Full Name:_____ Birth Date:_____ Age:_____ Sex: □ Male □ Female

Address:_____ 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:_____

Policy Number:_____

Primary Holder's name:_____

Primary Holder's DOB:_____

Primary Insurance Holder's last four of SSN:_____

Medical & Eye Health History

Main reason for examination today: _____

_____

Date of last eye exam:_____

Eye Doctor's name:_____

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: _____

_____

Primary Care Doctor:_____

_____

Have you been diagnosed with any of the following eye conditions? *(check all that apply)*

- □ Blindness
- □ Thyroid Eye Disease
- □ Retinal Detachment
- □ Glaucoma
- □ Corneal Dystrophy
- □ Macular Degeneration
- □ Implant Lens
- □ Diabetic Retinal Disease
- □ Eye/Eyelid Cancer
- □ Dry Eye Syndrome
- □ Hypertensive/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)**

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Check any of the following symptoms you experience:

- ☐ Eye Pain/Burn/Itching
- ☐ Light Sensitivity
- ☐ Fluctuating/Blurred Vision
- ☐ Double Vision
- ☐ Flashes of Light
- ☐ Headache
- ☐ Frequent Styes
- ☐ Mucus Discharge or Crusted Lids
- ☐ Change in Distance/Near Vision
- ☐ New Spots or Floaters
- ☐ Excess Tearing
- ☐ Loss of Side Vision
- ☐ Dryness 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
- ☐ Brain Injury *(If yes, complete brain injury section)
- ☐ Diabetes
- ☐ Gastrointestinal
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Psychiatric (Depression, etc.)
- ☐ Skin (Acne, cancer, etc.)
- ☐ Other: _____
- ☐ Arthritis
- ☐ Cancer
- ☐ Drug Sensitivity
- ☐ Heart Problem/Disease
- ☐ Kidney, Bladder
- ☐ Migraine or Headaches
- ☐ Respiratory (Asthma, etc.)
- ☐ Stroke
- ☐ Blindness
- ☐ Developmental Delay
- ☐ Ear/Nose/Throat Problems
- ☐ High Blood Pressure
- ☐ Lazy Eye/Amblyopia
- ☐ Neurological (MS, seizures)
- ☐ Rheumatoid Arthritis
- ☐ Thyroid

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:** _____

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

Visual History

Do you report/experience any of the following?

- ☐ Nausea when doing visual tasks
- ☐ Poor motor control (clumsiness)
- ☐ Poor reading comprehension
- ☐ Learning Disorders
- ☐ Closing or covering one eye
- ☐ ADD/ADHD
- ☐ Eyes frequently reddened
- ☐ Dyslexia
- ☐ Lose attention easily
- ☐ Eyelid Droop
- ☐ Lose place while reading
- ☐ When 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: _____

Dry Eyes

Over the past week, which of the following eye symptoms have you experienced? *(Check all that apply)*

- ☐ Glare
- ☐ Redness
- ☐ Tearing/Watery Eyes
- ☐ Stinging
- ☐ Night Driving Problems
- ☐ Eye Ache
- ☐ Burning
- ☐ Dryness
- ☐ Itching
- ☐ Grittiness
- ☐ Eyelids swollen or red along the lash margin
- ☐ Mattering on your eyelids when you wake up in the morning
- ☐ Decreased contact lens wearing
- ☐ Light Sensitivity
- ☐ Burning in the morning

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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
- ☐ Tendency to close or cover one eye
- ☐ Poor visual-motor (eye-hand/foot) coordination
- ☐ Difficulty tracking moving objects, balls, etc.
- ☐ Difficulty recognizing the same word in the next paragraph
- ☐ Head too close to the paper while reading or writing
- ☐ Difficulty following a sequence of directions
- ☐ Misalignment of digits or columns of numbers
- ☐ Errors copying from chalkboard, computer or book
- ☐ Difficulty completing assignments in allotted time
- ☐ Poor spelling
- ☐ Poor reading comprehension
- ☐ Confuses right and left
- ☐ Writing is crooked or poorly spaced
- ☐ Head tilt or movement
- ☐ Confuses similar looking words
- ☐ Whispers when reading silently
- ☐ Comprehension decreases over time
- ☐ Avoids near work or reading
- ☐ Does not visualize

Dizziness & Motion Sensitivity

Check all of the symptoms that are significant for you:

- ☐ Nausea, headache or dizziness when reading in a car
- ☐ Nausea, headache or dizziness from 3-D movies or rapid camera movements in video games or movies
- ☐ Hyper-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 head
- ☐ Avoidance 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
- ☐ Distance vision blurred and not clear—even with lenses
- ☐ Near vision blurred and not clear—even with lenses
- ☐ Clarity of vision changes or fluctuates during the day
- ☐ Poor night vision/cannot see well to drive at night

Dry Eyes
- ☐ Eyes feel "dry" and sting
- ☐ "Stare" into space without blinking
- ☐ Have to rub the eyes a lot

Reading
- ☐ Short attention span/easily distracted when reading
- ☐ Poor reading comprehension/cannot remember what was read
- ☐ Confusion of words/skip words when reading
- ☐ Difficulty/slowness with reading and writing
- ☐ Lose place/have to use finger to not lose place while reading

Doubling
- ☐ Double vision—especially when tired
- ☐ Have to close or cover one eye to see clearly
- ☐ Words move in & out of focus when reading

Light Sensitivity
- ☐ Normal indoor lighting is uncomfortable
- ☐ Outdoor light too bright—have to use sunglasses
- ☐ Indoor fluorescent light is bothersome or annoying

Depth Perception
- ☐ Clumsiness/misjudge where objects really are
- ☐ Lack of confidence walking/stumbling
- ☐ Poor handwriting (spacing, size, legibility)

Visual Comfort
- ☐ Eye discomfort/sore eyes/eyestrain
- ☐ Headaches or dizziness after using eyes
- ☐ Eye fatigue/very tired after using eyes all day
- ☐ Feel "pulling" around eyes

Peripheral Vision
- ☐ Side vision distorted/objects move or change position
- ☐ What looks straight ahead—isn't always straight ahead
- ☐ 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: _____