



Dr. Van C. Forrester

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Patient Basics When was your last eye exam? ___-___-___

What brings you in today? Eye Exam Contact Exam (Have you ever worn contacts? Yes No

Medical Check (Reason for medical check) _____

Last Name: _____ First Name: _____ Middle: _____

Marital Status: _____ Social Security #: _____ DOB:(___ / ___ / ___)

Sex: _____ Language: _____ Race: _____ Ethnic Group: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Preferred Phone (check one): Home Work Mobile **Patient would like to receive text? Yes No

Email Address: _____ ****Your email is used for your personal patient portal.**

Address: _____

City: _____ State: _____ Zip: _____

Employer's Name: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Financial Responsibility

- I understand and accept financial responsibility for all services rendered to me.
- I understand my insurance company is billed as a courtesy to me and payment of any bill is my responsibility.
- I understand if incorrect information is provided the bill is my responsibility.
- I permit a copy of this authorization to be used in place of the original as my signature on file and request payment of insurance benefits to Forrester Eye Associates, Dr. Van Forrester.

Parent/legal guardian Information if patient under 18

Name: _____ Age: _____ DOB:(___ / ___ / ___)

Address: _____ Phone: _____

Social Security #: _____ Sex: _____ Relationship to Patient: _____

Patient's or Guardian's Signature: _____ Date: _____

Authorization to Disclose Protected Health Information

It is our policy to Keep all matters regarding our patients in strict confidence due to HIPPA law. If you wish to have any of your relatives or close friends obtain your information regarding your medical records please list them below.

Persons I authorize to obtain medical information for me.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's or Guardian's Signature: _____ Date: _____

Insurance Information

We are required to follow proper coding and billing guidelines for eye examinations. Vision plans provide you with a "well vision" examination. This assumes healthy eyes that only suffer from focusing problems like nearsightedness, farsightedness, astigmatism and presbyopia. Any medical conditions affecting the eyes (allergies, high blood pressure, macular degeneration, glaucoma, high risk medication, dry eyes, cataracts, diabetes, etc.) are not covered by vision plans.

Your medical insurance will not pay for vision problems; your vision plan will not pay for medical problems.

We also require a current insurance card and ID at time of service to be provided to the front desk at check out.

MEDICAL INSURANCE

Name of Plan: _____

Primary Insured Person: _____

Relation to Patient: Self • Spouse • Parent

Primary's DOB: _____

Policy Number: _____

Primary's Employer: _____

VISION INSURANCE

Name of Plan: _____

Primary Insured Person: _____

Relation to Patient: Self • Spouse • Parent

Primary's DOB: _____

Policy Number: _____

Primary's Employer: _____

SECONDARY MEDICAL INSURANCE: _____

Policy Number: _____

Pharmacy/Doctor Information

Pharmacy: _____ Phone: _____ City: _____ State: _____

Doctor: _____ Phone: _____ City: _____ State: _____

Retinal Photography and Dilation

Retinal Photography - Please read the laminated form and decide if you want digital imaging of the back of your eyes.

I do want retinal photos. - I recognize that this is an elective service and may not be covered by insurance and I may be responsible for payment of \$35.00.

I do not want retinal photos.

Dilation

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

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.

I certify that the above is my complete medical and eye history to the best of my knowledge.

Date: ____ / ____ / ____

Patient Signature (Parent/legal guardian if patient under 18)

Privacy Practice Acknowledgement

The full Notices of Privacy Practices of Forrester Eye Associates is available by request from our check-in desk, and is also available online at www.forrestereye.com. I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: • Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. • Obtain payment from third-party payers. • Conduct normal healthcare operations such as quality assessments and physician certifications. I understood that the full Notice of Privacy Practices of Forrester Eye Associates contains a more complete description of the uses and disclosures of my health information and is available upon request. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Print Patient's Name (Parent/legal guardian if patient under 18)/: _____

Date: ____ / ____ / ____

Patient Signature (Parent/legal guardian if patient under 18)

Patient's Name: _____ Height: _____ Weight: _____

Past Medical History

Mark of any of the following Medical conditions that you have been diagnosed with and date of diagnosis

- | | | |
|---|--|--|
| <input type="radio"/> Anxiety _____ | <input type="radio"/> Arthritis _____ | <input type="radio"/> Asthma _____ |
| <input type="radio"/> Atrial fibrillation _____ | <input type="radio"/> Bone Marrow Transplant _____ | <input type="radio"/> BPH _____ |
| <input type="radio"/> Breast Cancer _____ | <input type="radio"/> Colon Cancer _____ | <input type="radio"/> COPD _____ |
| <input type="radio"/> Coronary Artery Disease _____ | <input type="radio"/> Depression _____ | <input type="radio"/> Diabetes (Type 1 or 2) _____ |
| <input type="radio"/> End Stage Renal Disease _____ | <input type="radio"/> GERD _____ | <input type="radio"/> Hearing Loss _____ |
| <input type="radio"/> Hepatitis _____ | <input type="radio"/> Hypertension _____ | <input type="radio"/> HIV/AIDS _____ |
| <input type="radio"/> Hypercholesterolemia _____ | <input type="radio"/> Hyperthyroidism _____ | <input type="radio"/> Hypothyroidism _____ |
| <input type="radio"/> Leukemia _____ | <input type="radio"/> Lung Cancer _____ | <input type="radio"/> Lymphoma _____ |
| <input type="radio"/> Prostate Cancer _____ | <input type="radio"/> Radiation Treatment _____ | <input type="radio"/> Seizures _____ |
| <input type="radio"/> Stroke _____ | <input type="radio"/> NONE | <input type="radio"/> OTHER: _____ |

Past Surgeries

Mark of any of the surgeries you have had on the following organs, and date.

- | | |
|--|--|
| <input type="radio"/> Appendix Removed _____ | <input type="radio"/> Joint Replacement Hip _____ |
| <input type="radio"/> Bladder _____ | <input type="radio"/> Kidney Biopsy (Right or Left) _____ |
| <input type="radio"/> Breast Biopsy (Right/Left) _____ | <input type="radio"/> Kidney Stone Removal (Right or Left) _____ |
| <input type="radio"/> Breast Reduction _____ | <input type="radio"/> Kidney Transplant _____ |
| <input type="radio"/> Breast Implants _____ | <input type="radio"/> Liver – Hepatectomy _____ |
| <input type="radio"/> Colectomy _____ | <input type="radio"/> Liver Transplant or Shunt _____ |
| <input type="radio"/> Colectomy (Diverticulitis) _____ | <input type="radio"/> Ovaries Removed (Endometriosis) _____ |
| <input type="radio"/> Colectomy (IBD) _____ | <input type="radio"/> Ovaries Removed (Cyst) _____ |
| <input type="radio"/> Coronary Artery Bypass _____ | <input type="radio"/> Ovaries Removed (Ovarian Cancer) _____ |
| <input type="radio"/> Gallbladder Removed _____ | <input type="radio"/> Prostate Removed (Prostate Cancer) _____ |
| <input type="radio"/> Heart - PTCA _____ | <input type="radio"/> Prostate Biopsy _____ |
| <input type="radio"/> Heart - Mechanical Valve Replacement _____ | <input type="radio"/> Spleen _____ |
| <input type="radio"/> Heart - Biological Valve Replacement _____ | <input type="radio"/> Testicles (Right/Left/Both) _____ |
| <input type="radio"/> Heart Transplant _____ | <input type="radio"/> Hysterectomy (Fibroids) _____ |
| <input type="radio"/> Joint Replacement Knee (Right/Left/Both) _____ | <input type="radio"/> Hysterectomy (Uterine Cancer) _____ |
| <input type="radio"/> Other _____ | <input type="radio"/> None |

Ocular Medical History

Mark of any of the following ocular conditions that you have been diagnosed with, date of diagnosis, and circle eye effected – Right R – Left L – Both B

- | | |
|---|--|
| <input type="radio"/> Allergic Conjunctivitis (R – L – B) _____ | <input type="radio"/> Blepharitis (R – L – B) _____ |
| <input type="radio"/> Cataract (R – L – B) _____ | <input type="radio"/> Contact Lens (R – L – B) _____ |
| <input type="radio"/> Corneal Dystrophy (R – L – B) _____ | <input type="radio"/> Diabetic Retinopathy, Background (R – L – B) _____ |
| <input type="radio"/> Diabetic Retinopathy, Proliferative (R – L – B) _____ | <input type="radio"/> Dry Eyes (R – L – B) _____ |
| <input type="radio"/> Glasses (R – L – B) _____ | <input type="radio"/> Glaucoma (R – L – B) _____ |
| <input type="radio"/> Macular Degeneration (R – L – B) _____ | <input type="radio"/> Macular ERM (R – L – B) _____ |
| <input type="radio"/> Narrow Angles (R – L – B) _____ | <input type="radio"/> Ocular Hypertension (R – L – B) _____ |
| <input type="radio"/> Pseudoexfoliation (R – L – B) _____ | <input type="radio"/> Retinal Tear (R – L – B) _____ |
| <input type="radio"/> Strabismus (R – L – B) _____ | <input type="radio"/> P V D (R – L – B) _____ |
| <input type="radio"/> Vitreous Floaters (R – L – B) _____ | <input type="radio"/> Other _____ |

Patient's Name: _____

Ocular Surgeries History

Mark of any of the following ocular surgeries that you had, date, and circle eye effected – Right R – Left L – Both B

- Blepharoplasty (R – L – B) _____
- Corneal Transplant (R – L – B) _____
- Eye Muscle Surgery (R – L – B) _____
- LASIK (R – L – B) _____
- LTP (R – L – B) _____
- Ptosis Repair (R – L – B) _____
- Strabismus Surgery (R – L – B) _____
- Trabeculectomy (R – L – B) _____
- Yag Capsulotomy (R – L – B) _____
- Cataract Surgery (R – L – B) _____
- DSAEK (R – L – B) _____
- Intravitreal Injections (R – L – B) _____
- LPI (R – L – B) _____
- PRK (R – L – B) _____
- Punctal Plugs (R – L – B) _____
- Retinal Laser (R – L – B) _____
- Tube Shunt (R – L – B) _____

Medications

We may be able to pull your current medication list over with the pharmacy information.

Allergies

Please describe reaction for each allergy.

Social History

Your smoking status: Former Smoker – Started smoking date: _____ Quit smoking date: _____
 Current Smoker – When did you start smoking? _____ Packs per day? _____
 Never Smoked

Have you ever used drugs? Yes No If yes what type? _____ IV drug use? Yes No

Do you drink alcohol? Yes No How many drinks per day? _____
How many times have you have more than 5 drinks per day in the last year? _____

Do you feel safe at home? Yes No
Do you drive in the day time? Yes No
Do you drive at night? Yes No

Do you Exercise? Several times a day Once a day A few times a week A few times a month Never

Family History

Condition	Family Member
<input type="radio"/> Diabetes	_____
<input type="radio"/> High Blood Pressure	_____
<input type="radio"/> Heart Disease	_____
<input type="radio"/> Thyroid	_____
<input type="radio"/> Retinal Disease	_____
<input type="radio"/> Blindness	_____
<input type="radio"/> Glaucoma	_____
<input type="radio"/> Macular Degeneration	_____