IVC
INDIANAPOLISVISIONCARE
ENHANCING VISION FOR LIFE

## Patient Information Record

Patient's Last Name_____ First Name _____ MI _____

Address _____City _____ State _____ZIP _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Social Security No. _____ Birth Date _____ Sex ☐ M ☐ F Age _____

Occupation & Employer _____

Marital Status _____

Name of Spouse or Nearest Living Relative _____ Relationship _____

Phone Number _____ Address (if different that above) _____

* Part of your Annual Eye exam requires Retinal Photography, the doctor will determine whether we can bill this service medically or not. If we cannot bill it to your medical insurance the charge for this test is $39.00

### Financial Responsibility

We are happy to file insurance claim forms or take assignment on your medical/vision plans of which state you are a member. We will do all we can to help receive maximum benefits, however, in the event that the plan sponsor determines that you are ineligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

_____ _____

Signature of patient or person acting on patient's' behalf Date

### HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing the consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allowed for these of information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

_____ _____

**HIPPA Consent Signature (Policy on Back side of page)** Date

## Medical History

Name of Primary Care Physician _____ Specialty Physician _____

Allergies: List all known medical allergies and environmental allergies

_____

Medications: Please list below (or provide a list of) all medications, including eye drops, nonprescription drugs, vitamins, herbal supplements. Please include dosage of all medications prescribed or over the counter.

_____

_____

| Do you currently have any of the following problems? | Yes | NO | If yes, please explain |
|---|---|---|---|
| **Ear/Nose/Throat problems** (hearing loss, sinus problems, sore throat) | ☐ | ☐ | _____ |
| **Neurological Problems** (numbness, weakness, headaches, paralysis) | ☐ | ☐ | _____ |
| **Psychiatric Problems** (depression, anxiety) | ☐ | ☐ | _____ |
| **Cardiovascular Problems** (heart disease, high blood pressure, heart arrhythmia) | ☐ | ☐ | _____ |
| **Respiratory** (asthma, bronchitis, shortness of breath) | ☐ | ☐ | _____ |
| **Gastrointestinal Problems** (heartburn, abdominal pain, diarrhea) | ☐ | ☐ | _____ |
| **Urinary Problems** (pain or discomfort, blood in urine) | ☐ | ☐ | _____ |
| **Musculoskeletal Problems** (muscle aches, joint pain, arthritis) | ☐ | ☐ | _____ |
| **Skin Problems** (rashes, excessive dryness, rosacea) | ☐ | ☐ | _____ |
| **Endocrine** (diabetes, thyroid problems) | ☐ | ☐ | _____ |
| **Hematologic/Lymphatic** (anemia, bleeding problems) | ☐ | ☐ | _____ |
| **Allergy/Immunologic** (environmental allergies, immune-compromising diseases) | ☐ | ☐ | _____ |

Do you currently have any of these eye related symptoms?

| | Yes | NO |
|---|---|---|
| Blurred Vision | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Dry, Itchy, Red or Burning Eyes | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ |
| Sandy Gritty Feeling | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ |
| Eye Pain/Soreness | ☐ | ☐ |
| Chronic Infection of Eye/Lid | ☐ | ☐ |
| Stye/Chalazion | ☐ | ☐ |
| Flashes/Floaters in Vision | ☐ | ☐ |

Have your immediate family members (parents, siblings, grandparents) have any of the following conditions?

| | None | Relationship |
|---|---|---|
| Cataracts | ☐ | _____ |
| Glaucoma | ☐ | _____ |
| Eye Injury | ☐ | _____ |
| Crossed/Lazy Eye | ☐ | _____ |
| Retinal Detachment | ☐ | _____ |
| Retinal Degeneration | ☐ | _____ |
| Macular Degeneration | ☐ | _____ |
| Blindness | ☐ | _____ |
| Diabetes (type 1 or 2) | ☐ | _____ |
| Hypertension | ☐ | _____ |
| Hyperthyroidism | ☐ | _____ |
| Hypothyroidism | ☐ | _____ |
| Cancer | ☐ | _____ |

Surgeries: List any previous surgeries, including eye surgeries and laser procedures.

_____

Height _____ Weight _____ Are you pregnant/nursing? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Frequency _____

Do you currently smoke? ☐ Yes ☐ No If yes, how much? _____ How long have you been smoking? ____

If no, have you previously been a smoker? ☐ Yes ☐ No

Patient or Guardian Signature _____ Date _____