COLORADO EYE CENTER
THE CARE YOU DESERVE

PATIENT INTAKE FORMS

*Thank you for choosing **Colorado Eye Center** as your eyecare health provider. We are delighted to have you as our patient and appreciate the confidence you have placed in us.*

PATIENT INFORMATION

Legal Name_____ **Preferred Name** _____

Street Address_____

City _____ **State** _____ **Zip Code** _____

Date of Birth_____ **Gender** ☐ **Female** ☐ **Male** **Social Security #**_____

Mobile Phone_____ **Home Phone**_____ **Work Phone**_____

Email Address_____ **Preferred Phone** _____

Employer _____ **Occupation**_____

Marital Status____ _____ **Name of Spouse/Partner**_____

If patient is a student – School_____ **Grade** _____

If minor
Responsible Party _____ **DOB**_____ **SS#**_____

Preferred Method of Contact (check one/per contact need)

Appointment Reminders ☐ **Phone** ☐ **Text** ☐ **Email**
Annual Eye Exam ☐ **Phone** ☐ **Text** ☐ **Email** **Postcard** ☐ **Schedule Today** ☐
Orders Glasses/ Contacts ☐ **Phone** ☐ **Text** ☐ **Email**

What is the reason for today's visit? ☐ **Eye Exam** ☐ **Eye Problem** **Other**_____

Are you interested in updating your glasses? ☐ **Yes** ☐ **No** ☐ **Maybe**

Date of last eye exam_____ **Were your eyes dilated?** ☐ **Yes** ☐ **No**

Previous Doctor or Office Location_____

How did you hear about Colorado Eye Center? _____

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INSURANCE DETAIL

Is the patient the primary cardholder on the insurance you will be using? ☐ Yes ☐ No

If no, please fill out below:

Cardholder Name_____ Relationship to Patient_____

Cardholder Date of Birth_____ Cardholder's Last 4 digits of SSN_____

VISION Insurance (check one)

☐ VSP ☐ Eyemed ☐ Blue View Vision ☐ Cigna Vision ☐ Aetna Vision

☐ United Healthcare ☐ Other_____

#ID or last 4 digits of SSN_____

MEDICAL Insurance (check one)

☐ Medicare ☐ Anthem ☐ Blue Cross/Blue Shield ☐ Cigna ☐ Aetna

☐ United Healthcare ☐ Other_____

Insured ID#_____

YOUR HEALTH & MEDICAL CONDITIONS (check all that apply)

EYES ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Kerataconous

☐ Retinal Problems ☐ Amblyopia ☐ Lazy Eye ☐ Other_____

EYE SURGERY ☐ Cataracts ☐ Retinal ☐ LASIK ☐ PRK ☐ RK

☐ Cosmetic ☐ Other_____

GENERAL ☐ Cancer ☐ Recent Weight Loss ☐ Recent Weight Gain ☐ Childbirth

☐ Trauma or Congenital Disorders _____

EAR / NOSE/ THROAT ☐ Hearing loss ☐ Sinus conditions ☐ Other _____

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YOUR HEALTH & MEDICAL CONDITIONS (continued)

NEUROLOGICAL ☐ Migraine ☐ Seizures ☐ Multiple Sclerosis ☐ ADD

☐ Dyslexia ☐ Learning Disability ☐ Head injury (date _____,

☐ Psychological/Psychiatric_____

CARDIOVASCULAR ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ Other_____

ENDOCRINE ☐ Diabetes Type I ☐ Diabetes Type II ☐ Thyroid ☐ Other

RESPIRATORY ☐ Asthma ☐ COPD ☐ Other

IMMUNE DISORDERS ☐ Sjogren's ☐ HIV-AIDS ☐ Other

BONE/MUSCLE/JOINT ☐ Arthritis ☐ Gout ☐ Other

SKIN ☐ Shingles ☐ Rosacea ☐ Acne ☐ Other _____

GASTROINTESTINAL ☐ Stomach ☐ GI disorder ☐ Hepatitis ☐ Other_____

GENITOURINARY ☐ Kidney / bladder ☐ Are you pregnant Yes / No or nursing Yes / No

BLOOD & CHOLESTEROL ☐ High cholesterol ☐ Anemia ☐ Bleeding ☐ Other_____

Height _____ Weight _____ Last medical exam_____

Doctor's name/ office location_____

Allergies _____

Please list ALL MEDICATIONS you are currently taking. This includes all prescription, non-prescription, homeopathic and birth control

On average, how much time each day do you work on a computer? _____

Do you use any eye drops (prescription or non-prescription)? Yes / No If yes, please list: _____

Please describe any bad reaction to eye drops, contact lenses or contact lens solutions. _____

Do you currently wear contact lenses? Yes I No If no, are you interested in wearing contact lenses? Yes I No

If yes, what is the brand you are currently wearing? _____

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FAMILY MEDICAL HISTORY

Check all that apply

CANCER	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
DIABETES TYPE I	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
DIABETES TYPE II	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
HYPERTENSION	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
HYPERTHYROIDISM	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
HYPOTHYROIDISM	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
CATARACT	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
GLAUCOMA	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
MACULAR DEGENERATION	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
OTHER EYE DISEASES	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter

OTHER

PATIENT OR GUARDIAN SIGNATURE _____ **DATE**___/____/_____

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PRIVACY CONSENT FORM

In the course of providing service 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.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Health Information Privacy Practices, the use and disclosure 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 for purposes of payment includes submission to a billing agent or vendor for processing claims or obtaining payment: our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment, our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Health Information Privacy Practices.

Our Notice of Health Information Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at anytime unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or: disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Health Information Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Health Information Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

PATIENT NAME _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE _____

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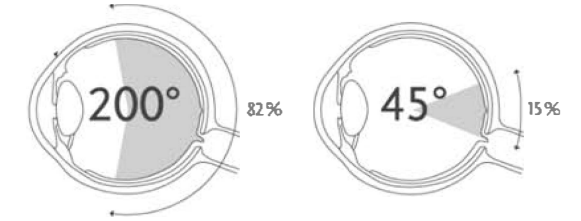
optomap
Retinal Exam

Colorado Eye Center is pleased to provide the most advanced technology for eye health screening. During your comprehensive eye exam, a thorough screening of the retina is critical to determine the health of your eye. When detected early, most retinal conditions and other diseases, can be treated successfully. **optomap** captures a digital image of your retina. When used in addition to traditional exam techniques, it can significantly improve the doctor's ability to detect abnormalities from eye disease, changes that take place, and general diseases, such as diabetes and high blood pressure. **optomap** is not a substitution for dilation and dilation may still be required.

optomap Benefits:

- **Quick, safe, and efficient** screening for children and adults, with no side effects.
- In most cases, **dilation may not be required.**
- Provides you and your family the **best standard of care.** We are able to help many of our patients discover potentially sight-threatening diseases such as glaucoma, and macular degeneration.
- **Up to 82% of your retina captured** in one scan, as compared to 10-15% with traditional methods.



with optomap ultra-widefield retinal imaging | without optomap

Our doctors highly recommend this procedure for all of our patients as part of their comprehensive eye exam.

The additional cost of $_____ , for including **optomap** in your exam is not generally covered by vision or health plan benefits.* The cost is the responsibility of the patient at the time of the exam and can be paid for with an (FSA) flexible spending account or (HSA) health savings account.

***If it is a covered benefit, we will submit for reimbursement.**

CONSENT FORM

By signing this form, you are consenting to have the optomap Retinal Scan performed as part of today's eye exam. Please check one:

☐ **YES,** I understand the benefits of **optomap** Retinal Scan and I would like to include it in my comprehensive exam.

☐ **NO,** I do NOT want the **optomap** Retinal Scan today.

REMINDER: If you elect to have dilation only or if dilation is required, the side effects include light sensitivity and blurred vision 4-6 hours post the exam.

PATIENT OR GUARDIAN SIGNATURE _____ **DATE**___/____/_____