Name: *First* _____ *MI*_____ *Last* _____

Address _____City _____ State _____ Zip_____

Date of Birth_____Age _____ Gender: Male / Female

Marital Status: Married _____ Single _____Divorced _____ Widowed _____

Occupation _____ Employer _____

Responsible Party Name: _____Relationship to Patient_____

Address if different than above: _____

| Contact Information | Preferred contact method | Permission to leave a detailed message ( Please circle all that pertain) |
|---|---|---|
| Home Phone: | | Orders / Appointments / Test results / Health info. / No |
| Cell Phone: | | Orders / Appointments / Test results / Health info. / No |
| E-mail: | | Orders / Appointments / Test results / Health info. / No |
| Text Message: | | Orders / Appointments / Test results / Health info. / No |
| Standard Mail: | | Orders / Appointments / Test results / Health info. / No |

Primary Care Physician: Name_____

Location_____Phone_____

I (*Do/ Do Not*) consent to communications with my primary care physician regarding my ocular health.
*(please circle)*

## *Optomap Waiver*

The Optomap (digital image of the retina) will be done annually for every patient UNLESS a waiver is signed. Dr. Seraly wants ALL patients to have a digital image of the retina annually with the new scanning digital imaging system. The test is only $39.00.
Retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy can now be detected significantly earlier with this simple screening.

EARLY DETECTION IS CRUTIAL.

I agree to the Optomap
Signature: _____
Date: _____

I do not wish to have the Optomap today
Signature: _____
Date: _____

**PLEASE INITIAL EACH:**

_____**FINANCIAL POLICY**

Patients who have medical/vision insurance should know that we try to submit all services directly to your insurance, but the patient or insurance holder, is responsible for any payments/deductibles that are not paid by the insurance. We must emphasize that as medical/vision care providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility from the date services are rendered. All insurance forms processed by this office are assigned to this practice. Your cooperation in complying with the terms of this assignment is appreciated.

_____**CONTINUING CARE**

I understand that it is my responsibility to follow my doctor's advice for the care of my eyes. I understand it is my responsibility to make follow-up appointments as instructed by the doctor or the doctor's staff.

_____**OPTICAL ORDERS**

All prescription glasses are custom made to meet the unique visual needs of the patient. While glasses are not returnable, we make every effort to ensure patient comfort. If there are issues with adaptation to a prescription, time is of the essence. Many vision care plans only offer a 30 day window to make any changes. All measurements, adjustments, and professional cleanings (in an ultrasonic bath), are available free of charge for all orders placed in our optical. (Outside spectacles may or may not be serviced, at the discretion of the optician, if risk of breakage is a concern.) A minimum of a 50% deposit is required to place an order. All orders must be paid in full before glasses can be dispensed. The patient must be present at the time of dispensing, so the glasses can be custom fit.

## PATIENT INSURANCE AUTHORIZATION

I authorize Dr. Seraly to submit claims to my insurance carrier or its intermediaries for all services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payments check(s) directly to the physician rendering the services. I understand that all or a portion of my benefits may not be paid and that I will be responsible for any balance owed on the services rendered. I authorize Dr. Seraly to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

Signature: _____ Date: _____/_____/_____

## PATIENT PRIVACY NOTICE

The privacy notice that we have given you describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully and sign and date below. We will keep a copy of this release in you records. Please keep and take home the Privacy Notice, if you choose to keep it as your record of information. No one else may sign for you. All minors under the age of 18 must sign themselves, or have a legal guardian sign this notice for them.

Signature: _____ Date: _____/_____/_____

**Name:** _____

**Date**_____

**How did you hear about our practice?**

_____

**Are you allergic to any medication(s)?** Yes / No

Please List_____

**Are you having an eye or vision problems?**

_____

_____

**What is your occupation?** _____

**Are you experiencing any of the following:** (circle)

| | | | |
|---|---|---|---|
| Blurred Vision | Computer Fatigue | Eyestrain | Double Vision |
| Itching | Burning | Water eyes | Dryness |
| Redness | Flashing Lights | Floating Spots | Glare |

**Do you wear corrective lenses?**

| | | | |
|---|---|---|---|
| Glasses | Contacts | Both | Neither |

**Are you interested in:** Contact Lenses / Lasik / Neither

**Ocular History:**

| | | |
|---|---|---|
| Lazy Eye | Yes | No |
| Cataract | Yes | No |
| Age-related Macular Degeneration | Yes | No |
| Glaucoma | Yes | No |
| Diabetic Retinopathy | Yes | No |
| Dry Eye | Yes | No |
| Eye Infection, Inflammation, or Allergy | Yes | No |
| Floaters and/or Flashes of Light | Yes | No |
| Iritis or Uveitis | Yes | No |
| Retinal Defect or Detachment | Yes | No |
| Eye Surgery or Injury Please list: | Yes | No |
| Other | | |

**Please list all medications you are taking and the condition being treated**:_____

_____

_____

_____

_____

**Review of Systems:** (Circle)

| | |
|---|---|
| **General**: | Pregnancy/Nursing, Cancer, Other, None |
| **Ear/Nose/Throat**: | Hearing loss, Dry Mouth, Other, None |
| **Nuero**: | Multiple Sclerosis, Migraines, Autism, Other, None |
| **Psych:** | Depression, Anxiety, Attention Deficit, Other, None |
| **Cardio:** | Hypertension, Stroke, Heart disease, Other, None |
| **Respiratory:** | Asthma, Sleep Apnea, Other, None |
| **Gastrointestinal:** | Crohn's, Colitis, Acid Reflux, Other, None |
| **Genitourinary:** | Kidney disease, Other, None |
| **Musc/skel:** | Osteoporosis, Ankylosing Spondylitis, Other, None |
| **Skin:** | Rosacea, Eczema, Psoriasis, Other, None |
| **Endocrine:** | Diabetes: Type 1, Type 2, Thyroid issues, Other, None |
| **Blood/Lymph:** | Hypercholesterol, Anemia, Other, None |
| **Allergy Immune:** | Allergies, Arthritis, Other, None |

**Please List Other:** _____

_____

_____

**Family History**

| | |
|---|---|
| Cancer | Grandparent/Mother/Father/Sibling/Child/None |
| Diabetes | Grandparent/Mother/Father/Sibling/Child/None |
| Hypertension | Grandparent/Mother/Father/Sibling/Child/None |
| Hyperthyroid | Grandparent/Mother/Father/Sibling/Child/None |
| Macular Degeneration | Grandparent/Mother/Father/Sibling/Child/None |
| Glaucoma | Grandparent/Mother/Father/Sibling/Child/None |
| Other | |

**Alcohol Use** Yes / No

(_____drinks per day or _____drinks per week)

**Smoking Status:** Never smoked / Former smoker / Current smoker

(_____cigarettes per day OR _____packs per week)

**Signature** _____