THE OFFICE OF

BRETT W. HAMILTON, O.D.

CONFIDENTIAL PATIENT INFORMATION

Date: _______/________/_______

PLEASE PRINT

Dr. Mr. Mrs. Ms. Miss ____ ❑ Male ❑ Female

Address ____ City/State: ___________________________ Zip: ___________

Home Phone: __________________________ Cell/Pager: ____________________________ Work: _________________________

Age: _________ Date of Birth: ______/______/_________ SS #: _______-_______-_________ Email: _________________________

Employer: ____ Occupation: __________________________________

In Case of Emergency, Contact: ____ Phone: _________________________

Primary Care Physician: ____ City ____

Phone #: ____________________________ Date of Last Visit: ____________________

Referred by: ❑ Phone Book ❑ Insurance ❑ School ❑ Drive By ❑ Advertisement ❑ Website ❑ Other ________________

❑ Doctor ____________________________________ ❑ Patient ______________________________________

If patient is a child or adolescent, please complete the following:

Legal Guardian's Name: ____ Occupation: _______________________________

Cell Phone: __________________________ Work Phone: _________________________ Employer: _________________________

MEDICAL HISTORY

List any allergies to medicines or other substances:____

List any medication you are taking (prescription or otherwise):____

List any reasons for recent hospitalization or surgery:____

Review of Systems: Do you currently or have you ever had any problems in the following areas:

	Yes	No		Yes	No		Yes	No
Eyes			**Endocrine**			**Neurological**		
Loss of vision	___	___	Thyroid	___	___	Headaches	___	___
Blurred vision	___	___	**Bones/Joints/Muscles**			Migraines	___	___
Double vision	___	___	Rheumatoid arthritis	___	___	Seizures	___	___
Eye injury	___	___	Joint pain	___	___	**Respiratory**		
Eye surgery	___	___	**Hematological**			Asthma	___	___
Floaters	___	___	Anemia	___	___	Chronic bronchitis	___	___
Flashes of light	___	___	**Vascular/Heart**			Emphysema	___	___
Glare/Halos	___	___	Diabetes	___	___	**Skin**	___	___
Cataracts	___	___	High blood pressure	___	___	**Psychiatric**	___	___
Glaucoma	___	___	Heart pain	___	___	**Gastrointestinal**		
Eye pain or soreness	___	___	High cholesterol	___	___	Diarrhea	___	___
Retinal disease	___	___	**Ear/Nose/Throat/Mouth**			**Genitourinary**		
Crossed/lazy eye	___	___	Allergies/Hay fever	___	___	Kidney/Bladder/Genital	___	___

Social History

Do you use tobacco?	___	___	Do you use illegal drugs?	___	___	Do you drink alcohol?	___	___

Have you been exposed to or infected with (circle): Gonorrhea Hepatitis HIV Syphilis

Family History

Please note any family history (parents, grandparents, siblings, and/or children—living or deceased) for the following conditions:

Blindness	___	___	Cancer	___	___	High blood pressure	___	___
Retinal detachment	___	___	Heart disease	___	___	Macular degeneration	___	___
Glaucoma	___	___				Diabetes	___	___

As a courtesy, we will file most primary insurance claims for you if we have the following information:

1. ***Photocopies of the front and back of your valid insurance ID card(s).***
2. ***Authorization to file insurance claims and receive direct payments for services.***
3. ***Notification of changes in your insurance coverage, address or phone number.***

Primary Medical Insurance: ____ Phone #: _______________________
Name of Policy Holder: ____ Relationship to Patient: __________________________
Policy Holder's date of birth: _____________ Employer: _________________________________ PCP Referral Required: ❑ Yes ❑ No
Policy #:_________________________________ Group #: ______________________________ PCP: __________________________

Secondary Medical Insurance: ____ Phone #: _______________________
Name of Policy Holder: ____ Relationship to Patient: __________________________
Policy Holder Date of Birth: _____________ Employer: __________________________________PCP Referral Required: ❑ Yes ❑ No
Policy #: ________________________________ Group #: ________________________________ PCP: ________________________

Vision Plan: ____ Phone #: ________________________
Name of Policy Holder: ____ Relationship to Patient: ________________________
Policy Holder's date of birth: ____________ Employer: ________________________________
Policy #:_______________________________ Group #: ______________________________

DILATION AND OPTOMAP

It is extremely important that Dr. Hamilton obtain a full view of the inside of your eyes. This allows for a more thorough examination and an increased ability to rule out/monitor diseases affecting the eyes such as cataracts, glaucoma, macular degeneration, malignant melanoma, retinal holes, tears and detachments., as well as changes due to diabetes, high blood pressure, and increased cholesterol. This view may obtained through dilation ($19) or an Optomap ($34). Dilation uses drops to obtain this view leaving your eyes light sensitive for 4-5 hours. The Optomap obtains the same view using a photograph. Optomap does not require any drops, has no side effects, and allows us to store a photograph on file for future reference. Both tests are useful and important. In most cases we recommend Optomap. Dr. Hamilton and his staff will discuss which test is best for you.

I have read this statement _________ (initials)

VISUAL FIELD SCREENING

Another important, but optional test is the Visual Field Test. Visual Field testing is performed in order that the doctor may assess the function of the central and peripheral (side) vision. With this computerized test, the quality of the entire visual field is assessed very accurately. Visual field testing helps the doctor evaluate glaucoma, diabetes, macular degeneration, brain tumors, as well as many other diseases. There is an additional charge of $17.00 for a visual field screening (many insurance carriers do not cover this test).

I would like to have this test _________ (initials)

INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information. I have the right to refuse
I have been offered and/or read the <u>*Notice of Privacy Practices*</u> for Brett W. Hamilton, O.D. and agree to continue my care with Brett W. Hamilton, O.D. under said terms. I hereby authorize Brett W. Hamilton, O.D. to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

____ ________________________________
Patient or Legal Guardian's Signature Date

FINANCIAL & INSURANCE FILING POLICY

All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or co pay If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, or does not pay within 45 days, we will require you to pay the balance. Payment for co pay, deductible, and non covered service is due at the time services are rendered. We accept cash, checks, money order, Visa, MasterCard, Discover, American Express, and Care Credit ________________ ***(initial here)***

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Brett W. Hamilton, O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Brett W. Hamilton, O.D. for any services furnished to me by Brett W. Hamilton, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, co pay, & non-covered services. Co pay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

____ ________________________________
Patient or Legal Guardian's Signature Date