THIRD AVENUE EYECARE

Name: ______________________________ Sex: Male / Female

Social Security #:____________ Birth Date:____________ Age: ____________

Phone Home:____________ Work: ____________ Cell:____________

Mailing Address:______________________ City/State/Zip: ____________

Email Address:______________________________

Would you like to receive text message notifications? Y / N

Race: (circle) American Indian Asian Black/African American Caucasian Hispanic Pacific Islander Other Decline

Occupation:____________________Employer:____________________

How were you referred to our office:______________________________

Primary Care Physician:____________ Phone:__________ Last Visit:____________

Previous Eye Dr.:____________ Phone:__________ Last Visit:____________

Do you wear **glasses: YES / NO** how long ______ ***and*** full-time / part-time ***for*** near / far / both

Do you wear **contact lenses**: **YES / NO** how long ______ soft / gas perm / specialty ________

<u>PATIENT</u> **EYE** HEALTH HISTORY

	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (eye turn)	☐	☐
Macular Degeneration	☐	☐
Keratoconus	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataracts Removed?	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinal Hole or Tear	☐	☐
Dry Eye Syndrome	☐	☐
Floaters	☐	☐
OTHER?	☐	☐

Please List ______________

<u>FAMILY</u> **HEALTH** and **EYE** HEALTH HISTORY

	YES	NO	**RELATIONSHIP**
Glaucoma	☐	☐	________
Amblyopia (lazy eye)	☐	☐	________
Blindness	☐	☐	________
Keratoconus	☐	☐	________
Cataracts	☐	☐	________
Macular Degeneration	☐	☐	________
Other Retinal Disorder	☐	☐	________
Strabismus (eye turn)	☐	☐	________
Arthritis	☐	☐	________
Cancer	☐	☐	________
Diabetes	☐	☐	________
Thyroid Disorder	☐	☐	________
High Cholesterol	☐	☐	________
Hypertension	☐	☐	________

Do you have any **CURRENT EYE** issues:

Blurred vision	☐	☐
Dryness	☐	☐
Burning	☐	☐
Itching	☐	☐
Floaters	☐	☐
Flashes of light	☐	☐
Halos	☐	☐
Sandy/Gritty feeling	☐	☐
Glare	☐	☐
Eye Pain	☐	☐
Eye Fatigue	☐	☐
Double vision	☐	☐

Other Symptoms not listed? ______________________________

Have you had any **EYE** surgeries? **YES / NO** (If ***yes***, what, which eye, when): ____________________

Have you had any other surgeries? **YES / NO** (If ***yes*** what and when): ____________________

REVIEW OF SYSTEMS

Do **you** currently, or have you ever had any problems in the following area:

SYSTEM	YES	NO
CONSTITUTIONAL		
Developmental Disability	☐	☐
Cancer	☐	☐
Type________________________________		
How treated: _________________________		
When:_____________Where:_____________		
EARS, NOSE, THROAT, MOUTH		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry throat/mouth	☐	☐
NEUROLOGICAL		
MS	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Migraines	☐	☐
Autism Spectrum Disorder	☐	☐
Head Trauma	☐	☐
If yes what and when: ________________________		
PSYCHIATRIC		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bi-Polar Disorder	☐	☐
Dementia	☐	☐
CARDIOVASCULAR		
Hypertension	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐
Stroke	☐	☐
If yes when:________________________________		
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Sleep Apnea	☐	☐
GASTROINTESTINAL		
Crohn's Disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Hepatitis (**circle**) A B C	☐	☐
IBD	☐	☐
GENITOURINARY		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐

SYSTEM	YES	NO
MUSCULOSKELETAL		
Arthritis	☐	☐
Osteoarthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
INTEGUMENTARY		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
ENDOCRINE		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Large Volume Blood Loss	☐	☐
Hypercholesterolemia	☐	☐
ALLERGIC/IMMUNOLOGIC		
HIV or AIDS (**if yes**, circle)	☐	☐
Drug Allergies	☐	☐
Seasonal Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐

Other condition not listed? _______________________
____
____

ARE YOU CURRENTLY **PREGNANT**? Y / N

ARE YOU CURRENTLY **NURSING**? Y / N

Do you take any **medications** or **supplements**? **YES / NO** (if ***yes*** please list):

____

____

Do you have any known **allergies? YES / NO** (if ***yes*** please list, including medications, food, and environmental):

____

____

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this portion directly with your doctor if you prefer.

CIRCLE THE FOLLOWING that apply to you:

1. **SMOKING**: CURRENT everyday/someday **/** FORMER SMOKER year quit: _________ **/** NEVER SMOKER
2. **DRINKING**: NON **/** TRIVIAL (less than 1 a day) **/** LIGHT (1-2 a day) / MODERATE (3-6 a day) / HEAVY (6+ a day)

FINANCIAL POLICY/INSURANCE AGREEMENT

VISION INSURANCE ____________________________________ **MEMBER NUMBER** _____________________________

MEDICAL INSURANCE __________________________________ **MEMBER NUMBER** _____________________________

We are committed to providing you with quality and affordable health care. As a courtesy, Third Avenue Eyecare verifies your benefits with your insurance company. A quote of benefits is not a guarantee of those benefits or payment. If we are a participating provider with your insurance plan, all payments are due at the time of service including but not limited to copays, overage or any other balance not paid by your insurance. **PLEASE NOTE:** retinal imaging is a part of Third Avenue Eyecare's standard of care. It helps your Optometrist find certain diseases and checks the health of your eyes. Since most insurance plans do not contribute to the cost of retinal imaging, your cost will never exceed $46. Payment for any materials such as glasses or contacts is due upon receipt of those materials. A deposit is required on glasses upon ordering. Should you write a check from an account with non-sufficient funds, it will be subject to a $60 returned check fee, applied per occurrence.

PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE.

The following is a list of insurances we accept: for **ROUTINE AND/OR MEDICAL:**
MEDICARE, CIGNA (most plans), ANTHEM BLUE CROSS BLUE SHIELD, UNITED HEALTH CARE, GREAT-WEST, HUMANA, VSP, AARP MEDICARE COMPLETE, MEDICARE ADVANTAGE, UMR

Medical insurance we **DO NOT** accept: Anthem CU exclusive, Cigna Connect or Local Plus, GEHA, Kaiser, UCHealth, UHC - Centura, Charter HMO, Doctors Choice, Rocky Mtn Health or Navigate plans

I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARD TO PAYMENT OF FEES FOR SERVICES RENDERED BY THIRD AVENUE EYECARE. In the event that I default, I agree to pay, whether or not legal proceedings are instituted, all collection fees, and collection costs including but not limited to, collection agency fees, court costs, and attorney fees.

PATIENT OR GUARDIAN SIGNATURE: _____________________________________ **DATE:**_________________

HIPAA Notice of Privacy Practices

Third Avenue Eyecare
800 3rd Ave Longmont, CO 80501

THIS NOTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights (The following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request or receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You may have the right to have your physician amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone.

I have received and/or read notice of this office's HIPAA Notice of Privacy Practices

PATIENT OR GUARDIAN SIGNATURE: ____________________________________ DATE:_________________

EMERGENCY CONTACT

Please list a person to contact **in the case of an emergency**

Name ___________________________ Relationship_____________________ Phone number________________

AUTHORIZED INDIVIDUALS

I authorize the disclosure of my personal health information to the **persons listed below**:

Name: _____________________________________ **Relationship:**_______________________

Phone:______________________________________

Name: _____________________________________ **Relationship:**_______________________

Phone:______________________________________

I understand that I have the right to revoke this consent at any time by sending a written statement to Third Avenue Eyecare, except to the extent Third Avenue Eyecare has already made a disclosure in reliance upon my prior consent.

PRINT NAME ____

SIGNATURE ____

DATE ____