Ross Eyecare Group, P.C.

Welcome To Our Office

Welcome to Ross Eyecare Group, P.C.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Cell Phone

Email Address | Spouse or Parent(s) Name | Person Responsible for Account (Must sign at bottom)

	ft	in	cm/m	
Height				◉ ft in ○ cm ○ m
Weight				◉ lbs ○ kg

☐ Caucasian
☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian Or Other Pacific Islander
☐ Other Race
☐ Native American
☐ Not Disclosed
☐ White

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) _____
☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

Primary Insurance Information

Name and Address of Primary Insurance Company or Routine Vision Provider | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

Secondary Insurance Information

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts
90 days old are subject to collection fees. There will be a service charge on all returned checks.
Payment from my insurance is to be paid directly to Ross Eyecare Group, P.C.. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Signature

Name

Ross Eyecare Group, P.C.

PATIENT HISTORY AND INFORMATION

Dr. _____ _____ _____

Primary Care Provider | Name Of Provider's Office | Phone Number

VISUAL HISTORY

Current Occupation : _____ Years _____ Employer _____

Do you use a computer ? ○ Yes ○ No How many hours/day _____ Distance from Computer _____

Do you drive? ○ Yes ○ No Mileage to work each way _____ Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses ? ○ Yes ○ No Reason for stopping _____

Do you currently wear contact lenses ? ○ Yes ○ No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort :	_____	_____	Distance Vision :	_____	_____	Near Vision :	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SPECTACLE LENS HISTORY

Do you currently wear glasses ? ○ Yes ○ No Since _____

Use of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned

☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses ? ○ Yes ○ No Are your sunglasses your current prescription ? ○ Yes ○ No

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SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Hobbies/ Interests : _____

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

Name

Ross Eyecare Group, P.C.

MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

Headaches	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Lazy Eye	○ Yes	○ No	Double Vision	○ Yes	○ No
Burning	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Dryness	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Excess Tearing/Watering	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Eye Pain or Soreness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Foreign Body Sensation	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No
Infection of Eye or Lid	○ Yes	○ No	Redness	○ Yes	○ No
Itching	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No
Mucous Discharge	○ Yes	○ No	Crossed Eyes	○ Yes	○ No

GENERAL HEALTH CONDITION

Fever	○ Yes	○ No	Kidney	○ Yes	○ No
Weight Loss	○ Yes	○ No	Muscles,Bones,Joints	○ Yes	○ No
Other Consti. Symptoms	○ Yes	○ No	Skin	○ Yes	○ No
Ears,Nose,Throat	○ Yes	○ No	Neurological (MS)	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Anxiety, Depression, Insomnia	○ Yes	○ No
Respiratory (Asthma)	○ Yes	○ No	Diabetes,thyroid	○ Yes	○ No
Gastrointestinal	○ Yes	○ No	Blood/Lymph (cholesterol)	○ Yes	○ No
Psychiatric	○ Yes	○ No	Allergic/Immunologic	○ Yes	○ No

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

if yes, who?

Lazy Eye	○ Yes	○ No	Arthritis	○ Yes	○ No
Blindness	○ Yes	○ No	Cancer	○ Yes	○ No
Cataract(s)	○ Yes	○ No	Diabetes	○ Yes	○ No
Color Blindness	○ Yes	○ No	Heart Disease	○ Yes	○ No
Glaucoma	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Lupus	○ Yes	○ No
Eye Turn	○ Yes	○ No	Stroke	○ Yes	○ No
			Thyroid Disease	○ Yes	○ No
			Others	○ Yes	○ No

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Ross Eyecare Group, P.C.
2625 Piedmont Road, N.E.
Atlanta, GA 30324

OPTOMAP® DIGITAL RETINAL IMAGING CONSENT FORM

In our continued efforts to bring the most advanced technology available to our patients, Ross Eyecare Group is now pleased to offer Optomap® digital retinal imaging as part of your comprehensive eye exam. Our doctors highly recommend that you have these images taken today in addition to having a thorough dilated examination. **Depending on the results of the Optomap imaging, the doctor will determine if dilation using a milder drop may be indicated.**

The procedure is fast, easy and comfortable. This is not an X-ray or ultrasound procedure; and nothing will touch your eye. We are simply taking a digital picture that is capable of imaging more of the inside of the eye, including the peripheral retina, than any previous technology has allowed us to see.

This permanent record is very valuable in assessing the current health of your eye; and for safeguarding the health of specific structures of your eye such as the retina, optic nerve, macula, and blood vessels. In some cases it may detect diabetic eye changes, macular degeneration, and high blood pressure changes. It will also serve as a baseline from which to compare, as we follow your health in subsequent years.

If you elect to have these photos taken the fee is **$39**. Routine retinal images are not covered by most vision plans and are commonly subject to a copay.

_____ Yes, I would like to have retinal photos taken of my eye for documentation.

_____ No, I do not wish to have retinal photos taken, unless the Doctor determines there is a medical need to do so.

Patient Signature:_____ Date: _____

Insurance Updates for Our Patients

As you may have already noticed, and will definitely observe during the course of your visit with us, there are several new items that you will be asked regarding your health history. Additionally, we will be asking if we may communicate with you via email and text regarding your visit with us as well as to provide future reminders for upcoming visits. Medicare now mandates that we ask these questions for every patient...whether or not they are covered by Medicare and that we set up what is called a "patient portal". This portal serves as a communication point between the doctors and our patients. Within four business days, we are required to send information to you through this patient portal summarizing your visit with us. Additionally, although at present, this is just a Medicare mandate, Medicare requires us to do this for every patient...whether or not they are covered by Medicare. Please note that even if you ask us not to contact you by email, we will give you written instructions on how to establish your patient portal account.

This is why we must ask for the following information:

Your email address: _____

Would you like to receive the patient portal log in information via email:

_____ Yes _____ No

Your preferred contact method:

_____ Email _____ Phone _____Regular Mail

_____ _____

(Printed Name) (Date)

INSURANCE RESPONSIBILITY

I, the undersigned, understand that I am ultimately responsible for payment in full for all charges incurred by me at Ross Eyecare Group, P.C. If my insurance company does not pay for services rendered or materials furnished by Ross Eyecare Group, P.C., or if for any reason my deductible has not been met, it is my responsibility to pay the usual and customary fees for said services and materials. I also realize that I am responsible for any co-payment and deductible required under my insurance. If this matter becomes a collection matter, I will assume all attorneys' fees, collection costs, and court costs incurred by Ross Eyecare Group, P.C. in its attempt to collect any and all outstanding debt on my account.

I authorize Ross Eyecare Group, P.C. to release any medical information necessary to process this claim.

DATE: _____ NAME: _____

SIGNATURE: _____

If the patient is a minor, the below signed represents the patient's legal guardian or parent:

DATE: _____ NAME: _____

SIGNATURE: _____

Designated Party Release

Ross Eyecare Group, P.C.

You may give **Ross Eyecare Group, P.C.** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (glasses and/or contact lens status, claims information, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient's Name	Date of Birth

At my request, I authorize **Ross Eyecare Group, P.C.** to disclose my protected health information to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

At my request, I also authorize **Ross Eyecare Group, P.C.** to communicate my protected health information to me via the following methods:

☐Leave detailed message on my home answering machine. Phone number: (___) ___-____

☐Leave detailed message on my voice mail at work. Phone number: (___) ___-____

☐Leave detailed message on my cell phone voice mail. Phone number: (___) ___-____

☐Fax detailed medical information. FAX number: (___) ___-____

☐E-mail detailed medical information. Email address_____

☐I agree to receive text messages to this mobile phone number (___) ___-____ reminding me about my upcoming appointments. I understand that SMS reminders are optional and that message & data rates may apply.

I understand that I may cancel this authorization at any time. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Ross Eyecare Group, P.C.** took in reliance on this authorization before receipt of written notice of cancellation.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of **Ross Eyecare Group, P.C.** I agree to assume such risks personally, and to hold **Ross Eyecare Group, P.C.** harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing **Ross Eyecare Group, P.C.** to transmit or deliver such information electronically.

Patient's Name	Date of Birth

David N. Ross, O.D.
Michael M. Bloom, O.D.
Robert D. Butterwick, O.D.
Matthew A. Mast, O.D.
Stephanie M. Ross, O.D.

ROSS EYECARE
GROUP

COVID-19 SCREENING QUESTIONS

Patient Name:_____ Date:_____

- Do you have a fever?
  ___No ___Yes

- Do you currently have a cough or shortness of breath?
  ___No ___Yes

- Are you experiencing any of the following?
  ___None of the following ___Muscle aches and pain
  ___New loss of taste or smell ___Chills or shaking
  ___Vomiting or diarrhea ___Sore throat

- In the past two weeks, have you (or anyone in your household) flown domestically or internationally?
  ___No ___Yes. If yes, please explain:

  _____

- In the past two weeks, have you (or someone in your household) been diagnosed, tested positive or quarantined under a doctors orders due to COVID-19?
  ___None of the following ___I tested positive for COVID-19
  ___I was tested but tested negative ___I was tested and am waiting results
  ___A doctor ordered me to quarantine for possible COVID-19
  ___Someone in my houshold tested positive
  ___Someone in my home has a fever, cough or difficulty breathing but has not tested positive

- In the past two weeks, have you been in close, unprotected contact with someone who has been diagnosed with COVID-19 or quarantined under a doctors order fo COVID-19?
  ___Yes ___No

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