

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)

Height	ft	in	cm/m	<input checked="" type="radio"/> ft in <input type="radio"/> cm <input type="radio"/> m
Weight				<input checked="" type="radio"/> lbs <input type="radio"/> kg

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American
<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	
<input type="checkbox"/> Other Race	

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

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

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) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

Name _____

Ross Eyecare Group, P.C.

MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

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

GENERAL HEALTH CONDITION

- | | | | | | |
|------------------------|---------------------------|--------------------------|-------------------------------|---------------------------|--------------------------|
| Fever | <input type="radio"/> Yes | <input type="radio"/> No | Kidney | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight Loss | <input type="radio"/> Yes | <input type="radio"/> No | Muscles,Bones, Joints | <input type="radio"/> Yes | <input type="radio"/> No |
| Other Consti. Symptoms | <input type="radio"/> Yes | <input type="radio"/> No | Skin | <input type="radio"/> Yes | <input type="radio"/> No |
| Ears,Nose,Throat | <input type="radio"/> Yes | <input type="radio"/> No | Neurological (MS) | <input type="radio"/> Yes | <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | Anxiety, Depression, Insomnia | <input type="radio"/> Yes | <input type="radio"/> No |
| Respiratory (Asthma) | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes,thyroid | <input type="radio"/> Yes | <input type="radio"/> No |
| Gastrointestinal | <input type="radio"/> Yes | <input type="radio"/> No | Blood/Lymph (cholesterol) | <input type="radio"/> Yes | <input type="radio"/> No |
| Psychiatric | <input type="radio"/> Yes | <input type="radio"/> No | Allergic/Immunologic | <input type="radio"/> Yes | <input type="radio"/> No |

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

if yes, who?

- | | | | | | |
|----------------------|---------------------------|--------------------------|---------------------|---------------------------|--------------------------|
| Lazy Eye | <input type="radio"/> Yes | <input type="radio"/> No | Arthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Blindness | <input type="radio"/> Yes | <input type="radio"/> No | Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Cataract(s) | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| Color Blindness | <input type="radio"/> Yes | <input type="radio"/> No | Heart Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Glaucoma | <input type="radio"/> Yes | <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Macular Degeneration | <input type="radio"/> Yes | <input type="radio"/> No | Kidney Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Retinal Detachment | <input type="radio"/> Yes | <input type="radio"/> No | Lupus | <input type="radio"/> Yes | <input type="radio"/> No |
| Eye Turn | <input type="radio"/> Yes | <input type="radio"/> No | Stroke | <input type="radio"/> Yes | <input type="radio"/> No |
| | | | Thyroid Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| | | | Others | <input type="radio"/> Yes | <input type="radio"/> 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

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)

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: _____

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
----------------	---------------