DR. GORDON RUSSELL, O.D. *DR. IAN KIRSTE, O.D.* *DR. JED LISTER, O.D.*
Office Manager: Berenice Assistant Managers: Jessica and Rhonda

PATIENT'S LEGAL NAME: Today's Date _____

Last _____First_____ MI____

DOB_____ Social Security# _____

Address_____ City_____ State_____ Zip_____

Home #_____ Cell# _____Text Ok? _____E-mail_____

PLEASE PROVIDE E-MAIL FOR ANY COMMENTS OR SUGGESTIONS

❑ Male ❑ Female ❑ Single ❑Married ❑ Widowed ❑Separated ❑Divorced

Occupation/Hobbies _____

ARE YOU USING INSURANCE TODAY? ❑ Yes ❑ No

ARE YOU HERE FOR A CONTACT LENS EXAM? ❑ Yes ❑ No

PRIMARY INSURANCE / PERSON RESPONSIBLE FOR PAYMENT:

Name of Insured / Guarantor_____

Health Ins. Co. _____ Vision CO. _____

Employer _____

DOB _____ Soc. Sec. # _____ Home Phone _____

Cell Phone_____ Relationship _____

Address (if different from patient) _____

SECONDARY INSURANCE:

Name of Insured / Guarantor_____

Health Ins. Co. _____ Vision CO. _____

Employer _____

DOB _____ Soc. Sec. # _____ Home Phone _____

Cell Phone_____ Relationship _____

Address (if different from patient) _____

DUE TO CONSTANT CHANGES AND VARIETIES OF INSURANCE PLANS, YOU WILL NEED TO PRESENT YOU INSURANCE CARD TO THE RECEPTIONIST EACH TIME YOU VISIT OUR OFFICE. IF YOU DO NOT HAVE YOUR CARD, PLEASE EXPECT TO PAY FOR THAT VISIT. WHEN INSURANCE INFORMATION IS RECEIVED, WE WILL FILE FOR YOU.

MEDICAL HISTORY

Name:_____ DOB:_____

List Current Medications(including eye medication)

_____

_____

_____

Any medication allergies? _____

_____

Last Eye Exam _____

Medical Dr. Name _____

Medical Dr. Phone _____

Last Medical Exam _____

Any known eye disease? _____

_____

List of Medical Surgeries? _____

_____

Are you pregnant or nursing No❑ Yes❑

Do you currently wear Glasses or Contacts? (Circle)

Is there a Family History of:

	(Relationship To You)
Blindness	_____
Cataracts	_____
Crossed Eyes	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Detachment	_____
Arthritis	_____
Cancer	_____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
Kidney Disease	_____
Lupus	_____
Thyroid Disease	_____
Other	_____

REVIEW OF SYSTEMS

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

	No	**Yes**
Constitutional		
Fever/Weight Loss/Gain	❑	❑
Cardiovascular/Vascular	❑	❑
Vascular Disease	❑	❑
High Blood Pressure	❑	❑
Ears, Nose, Mouth, Throat	❑	❑
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Respiratory	❑	❑
Asthma	❑	❑
Gastrointestinal	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Genitourinary	❑	❑
Genitals/Kidney/Bladder	❑	❑
Musculoskeletal	❑	❑
Arthritis	❑	❑

Integumentary	**No**	**Yes**
Skin	❑	❑
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Endocrine		
Diabetes	❑	❑
Thyroid/Other Glands	❑	❑
Hematologic/Lymphatic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic/Immunologic	❑	❑

Eyes	**No**	**Yes**
Loss of Vision	❑	❑
Distorted Vision	❑	❑
Loss of Side Vision	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body Sensation	❑	❑
Excess Tearing/Watering	❑	❑
Glare/Light Sensation	❑	❑
Chronic Infection of Eye Lid	❑	❑
Sties or Chalazion	❑	❑
Flashes/Floaters in Vision	❑	❑

Do you use eye drops?

❑*No* ❑ *Yes -what type?* _____

Do your eyes feel dry, painful, or sore?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

Do you ever experience episodes or periods of blurred vision?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

How often do your eyes feel tired?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

Do you have problems with your eyes when you are working on a computer, watching TV or reading?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

SOCIAL HISTORY

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

❑ Yes, I would prefer to discuss my Social History with the doctor.

Do you drive? ❑No ❑ Yes if yes, do you visual difficulty when driving?

_____

Do you use tobacco products? ❑No ❑Yes

If Yes, type/amount how long:_____

Do you use drink alcohol? ❑No ❑Yes

If Yes, type/amount/how long:_____

Do you use illegal drugs? ❑No ❑Yes

If Yes, type/amount/how long:_____

Have you ever been exposed to or infected with:

❑ Gonorrhea ❑Hepatitis ❑ HIV ❑Syphilis

Automated Visual Field Test $10.00

Virtually all of the major causes of blindness in the United States can be detected by the changes in the visual field.

A new and highly sophisticated computerized instrument enables us to provide a more thorough visual field screening analysis. The instrument checks for areas of loss of sight both in central and peripheral areas. Visual field testing can assist us in the early detection of glaucoma, retinal problems, some neurological diseases (**such as brain tumors and optic nerve diseases**), and enables us to better diagnose causes of headaches. Most visual field defects are not noticed by an individual until very late stages, we are committed to the prevention of eye disease and wish to stress that **early detection** can significantly increase the chance of curing a disorder or at least minimize the effect.

We strongly recommend that all of our patients receive this test as part of their comprehensive visual analysis. **Having this test administered will add $10.00 to the cost of the eye exam. Please check the appropriate box below stating your preference and sign this form at the bottom.**

- ❒ **I want** the Visual Field Screening (NOT COVERED BY INSURANCE)
- ❒ **I do not want** the Visual Field Screening

Optomap Retinal Imaging $25.00

This is an ultra-wide digital retinal imaging device that helps you and your eye doctor make informed decisions about your eye health and overall well-being. The Optomap device captures more than 80% of your retina which enhances your eye doctors ability to detect early signs of retinal disease. **These photos will be a permanent part of your electronic records; allowing the doctor to diagnose and manage eye diseases more accurately and should be a part of your yearly eye exam. This test adds $25.00 to the exam fee.**

- ❒ **I want** the digital retinal photographs. (NOT COVERED BY INSURANCE)
- ❒ **I do not want** the digital retinal photographs.

Dilated Retinal Exam $35.00

Dilating the pupil with eye drops allows us to obtain a much better view inside the eye in order to better detect such problems as glaucoma, cataracts, retinal detachment, macular degeneration, diabetes, high blood pressure, often before obvious symptoms.

We strongly recommend pupil dilation if you have never had them dilated or if any of the following applies to you:

- You are over the age of 55
- Have a family history of eye disease or health problems
- Recent onset of unusual visual symptoms such as floaters, flashes, pain or blurred vision.
- You have a high spectacle prescription.
- It has been more than two years since your last dilated retinal exam

While the drops used to dilate pupils have minimal side effects, some people may experience some mild blurred vision especially when reading, and some sensitivity to light for three to four hours or more. **Having this test administered will add $35.00 to the cost of the eye exam. Please check the appropriate box below stating your preference and sign this form at the bottom.**

- ❒ **I want** a dilated retinal examination. (COVERED BY SOME INSURANCES) **please verify with front desk.**
- ❒ **I do not want** a dilated retinal examination.
- ❒ I will reschedule for a dilated retinal examination.

Signature: _____ **Date:** _____

Dr. Gordon Russell
Dr. Ian Kirste
Dr. Jed Lister
3450 E. Main St.
Farmington, NM 87402

Phone: (505) 325-7070
Fax: (505) 325-5812

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge that I have received the Notice of Privacy Practices of SkyView EyeCare.

_____ -or- _____
(Signature of Patient) (Signature of Personal Representative)

_____ _____
(Date) (Relationship of Personal Representative to Patient)

Patient Payment Responsibility
Please read all the information below carefully. This is a binding legal document.

Patient Payment Liability (Insured)
I acknowledge that the insurance card and information provided with each visit is the correct and current information. I understand that it is my responsibility to inform SkyView EyeCare if a change in my insurance coverage occurs. I understand that not having the current billing information inhibits SkyView EyeCare from billing the services rendered on my behalf in a timely manner. If my insurance has a deductible, I understand it is my responsibility to inform SkyView EyeCare about the deductible amount and if the deductible has been met. I understand that I am legally responsible for all charges incurred whether or not they are paid by my insurance and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me. In the event of default, I agree to pay all cost of collection and reasonable attorney's fees.

Patient Payment Liability
All Professional Fees are due at time of service. I also understand that I am legally responsible for all charges incurred. I also understand that any unpaid balance shall be paid in full immediately. **I also agree and understand that all professional fees are non-refundable, such as eye exams and contact lenses fittings/follow-ups.**

Benefits Assignment Agreement
I hereby give authorization for payment of insurance to be made directly to SkyView EyeCare. I authorize SkyView EyeCare to apply for benefits on my behalf for covered services rendered by SkyView EyeCare.

Release of Information
I authorize the release of any medical information necessary to process claims. I also authorize the release if my medical records, inclusive of all results of my testing and other pertinent information acquired during my treatment to other physicians as deemed necessary. I understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance thereon in writing to SkyView EyeCare.

Consent for Treatment
I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his/her assistants or designees as is necessary in his/her judgment.

By Signing below, I am indicating my understanding of the above information. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I verify that the above demographics and insurance information is correct. I also agree to update this form with any changes as they occur.

_____ -or- _____
(Signature of Patient) (Signature of Personal Representative)

_____ -or- _____
(Date) (Relationship of Personal Representative to Patient)