PATIENT INFORMATION

Date: ____ / ____ / ____

First Name: _____ Date of Birth: ___/___/___

Middle Initial: _____ SSN: _____

Last Name: _____ Sex: ☐ Male ☐ Female

Name Preference: _____

Parents Name: (If Minor)_____

☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Minor Hispanic/ Latino? Y or N

Race: ☐ American Indian or Alaska Indian ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Cell #: ( ) _____ Home #: ( ) _____

Communication Preference: ☐Text ☐ Phone Call Email: _____

Mailing Address: _____

City: _____State: _____ Zip: _____

Medical Insurance: _____

Primary Care Physician, City/State: _____ Pharmacy, City/State_____

Insurance Agreement

I authorize the release of any information needed to provide medical treatment and service or to obtain authorizations or payments from the insurance company or other payer. Medicare and insurance companies sometimes have a deductible that must be met before they will pay. The patient is responsible for paying the covered charges until the deductible is met. I further agree to any charges not paid or covered by above mentioned insurance company to Hatfield Family Eye Care, PLLC. I have read and understand the information above and agree to pay for any services and/or materials I order that may not be covered by my insurance. I understand that I may receive a bill after the date of service, and I agree to pay the complete balances due if my insurance does not cover my claim in full.

Patient or Guardian Lifetime Signature: _____ Date: _____

Privacy Statement

I acknowledge that I have been offered a copy of the Hatfield Family Eye Care / Lisa Hatfield, O.D., Notice of Privacy Practices. I understand that my private information will not be shared with third parties, unless I have consented to share my records.

Patient or Guardian Signature Lifetime: _____ Date: _____

Please check all medical conditions that **YOU** have had in the past or currently have.

Constitutional
___ Cancer
___ Development Disabilities
___ Fatigue Syndrome

Ears, Nose, Throat
___ Laryngitis
___ Sinusitis
___ Dry Mouth
___ Hearing Loss

Neurological
___ Multiple Sclerosis
___ Migraine/ Headache
___ Stroke / CVA
___ Tumor
___ Cerebral Palsy
___ Epilepsy

Psychiatric
___ Bipolar Disorder
___ Anxiety Disorder
___ Attention Deficit
___ Depression

Cardiovascular
___ Heart Disease
___ Vascular Disease
___ High Blood

Respiratory
___ Emphysema
___ Bronchitis
___ Sleep Apnea
___ Chronic Obstruction
___ Asthma

Gastrointestinal
___ Ulcer
___ Acid Reflux
___ Celiac Disease
___ Crohn's Disease
___ Colitis

Genitourinary
___ Herpes
___ Kidney Disease

Musculoskeletal
___ Muscular Dystrophy
___ Gout
___ Osteoporosis
___ Arthritis
___ Fibromyalgia
___ Osteoarthritis

Integumentary
___ Rosacea
___ Psoriasis
___ Eczema
___ Shingles

Endocrine
___ Thyroid Dysfunction
___ Diabetes Type 1
___ Diabetes Type 2

Hematologic/Lymphatic
___ Anemia
___ Large Volume Blood Loss
___ High Cholesterol
___ Lupus
___ Environmental Allergies

Ocular
___ Macular Degeneration
___ Cataract
___ Cataract Surgery
Date: _____
___ Glaucoma
___ Keratoconus
___ Retinal Detachment
___ Dry Eyes

Other:
_____
_____
_____

Social History
Y / N Do you drink alcohol?
Frequency:_____
Y / N Do you use Tobacco
Type: _____
Frequency: _____
Y / N Are you pregnant/ breastfeeding
How many weeks:
_____

Do you take medications? □ Yes □ No If yes, please list:
_____

Do you have allergies/ medication allergies? □ Yes □ No If yes, please list:
_____

Family Health & Ocular History

Please review and circle any family members that currently have or have been diagnosed with the following medical conditions or diseases. (Parents, Siblings, Children)

MEDICAL	YES/NO	RELATIONSHIP	OCULAR	YES/NO	RELATIONSHIP
Cancer	Y / N	M / F / Bro / Sis / Ch	Macular Degeneration	Y / N	M / F / Bro / Sis / Ch
Diabetes	Y / N	M / F / Bro / Sis / Ch	Cataracts	Y / N	M / F / Bro / Sis / Ch
High Blood Pressure	Y / N	M / F / Bro / Sis / Ch	Glaucoma	Y / N	M / F / Bro / Sis / Ch
Thyroid Condition	Y / N	M / F / Bro / Sis / Ch			

Consent Form

Refraction (Glasses Prescription Evaluation)

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. It is a necessary and essential portion of your vision exam.

- ☐ YES, I would like the glasses portion of the exam (Covered only by vision insurance - $20 fee otherwise)
- ☐ NO, I do NOT want the glasses portion of the exam (If I check "no", I understand I WILL NOT receive a glasses prescription or glasses check today)

Optos (Retinal Imaging Screening)

The Optos is an advanced digital retinal screening that captures a high-resolution photograph of your retina, helping us to document, review, and compare the health of the retina over time. This technology helps Dr. Hatfield in diagnosing problems such as Macular Degeneration, Glaucoma, Retinal Holes, Detachments, Diabetes and Hypertension (all of which can lead to partial vision loss or blindness). **This is not recommended for individuals who experience seizures triggered by bright flashes.** **Medical conditions monitored by Dr. Hatfield are a separate fee determined by insurance coverage, so patient cost will vary.

- ☐ YES, I would like the Optos Screening for $29.00 / I would like Dr. Hatfield to use retinal imaging to manage my medical condition (fee determined by insurance coverage). I decline dilation.
- ☐ NO, I would like to be dilated instead (Dr. Hatfield will still be able to assess the health of your retina through the use of dilating drops)

Contact Lens Evaluation Agreement

If you desire a contact lens prescription there will be an evaluation fee in addition to routine exam fees. The evaluation will ensure that you are in the correct type of lenses based on your needs. This fee **(due at time of service)** will range from $65.00 to $95.00 depending on complexity of lens type/evaluation. **(Dependent on insurance)**

OR

IF you have received an evaluation at our office within the last three years prior to this visit and are fitted in the same lens type (e.g. spherical, toric, multifocal, RGP) the fee is reduced to $45.00, due at time of service. **(Dependent on insurance)**

- ☐ YES, I am interested in receiving a contact evaluation and agree to fees mentioned above
- ☐ NO, I do not wish to receive a contact lens evaluation

Glasses Prescription Acknowledgement (only applicable if receiving a refraction)

You may choose from the following methods of glasses prescription receipt:

- ☐ I know that I have access to my active glasses prescription **electronically** at any time from Hatfield Family Eye Care's **secure patient portal**, found on www.hatfieldfamilyeyecare.com.
- ☐ I choose to receive a physical **paper copy** of my glasses prescription upon the conclusion of my vision exam.

> **AT CHECKOUT ONLY:** I have received a physical paper copy of my glasses prescription from my exam today.
>
> **Signature:** _____ **Date**:_____

- ☐ I refuse to receive a copy of my glasses prescription at this time. I know that I may request a copy at any time.

Signature: _____ **Date**:_____