

Child Patient Demographics

Referred By (Circle One): Relative Friend Phone Book Website Insurance Doctor

Name of Person who referred you: _____

I hereby authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment or health care operations.

I accept full financial responsibility for services rendered by Spring Creek Eye Center and agree to pay all reasonable collection cost and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Spring Creek Eye Center should they elect to receive such payment. My signature below indicates that I have read and fully understand.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, **Spring Creek Eye Center** has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with **HIPAA** Regulations, a copy of the **Spring Creek Eye Center Privacy Policy & Practices** has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

{ } I have read, understand and acknowledge the *Privacy Policy & Practices* of **Spring Creek Eye Center**.

{ } I have elected not to read the *Privacy Policy & Practices* of **Spring Creek Eye Center**.

{ } A copy of the **Spring Creek Eye Center Policy & Practices** was given to me today.

Signature: _____ Date: _____

Privacy Options – In some cases, it is not possible to reach our patients during work hours to discuss test results, future appointments and account balances. Your response to the questions below will give us guidance when we cannot contact you personally.

May we leave a message, either on the answering machine or with the person answering the home phone,

regarding appointments? Yes No

With whom may we speak to regarding the insurance, billing questions or financial arrangements?

To whom may we speak? _____

With whom may we speak to regarding test results or other medical information?

To whom may we speak? _____

Pharmacy Information

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____

Today's Date _____

Patient Name: _____ Date of Birth: _____

Medical Doctor: _____

Phone _____ Fax _____

Address: _____

Please answer the following questions to the best of your ability.

Please describe your current eye problems: _____

Current Symptoms	Right Eye	Left Eye	How Long	Right Eye	Left Eye	How Long
Pain/Soreness of eye or eyelid				Light Flashes		
Eye or Eyelid redness				Floaters in Vision		
Burning Sensation				Temporary Vision Loss		
Sandy or Gritty feeling				Halos around lights		
Mucous Discharge				Computer Vision Strain		
Foreign body sensation				Headaches A.M. P.M.		
Itching				Reading Difficulty		
Watery Eyes				Weak / Lazy Eye		
Swelling of Eyelid(s)				Eye Misalignment		
Light Sensitivity				Vision Therapy / Exercises		
Blurred Vision				Vision Loss		
Double Vision				Other:		

Medical History / Review of Systems **Please Circle Any That Apply**

Pregnant	Yes	No	
Seasonal Allergies	Yes	No	
Food Allergies	Yes	No	Please List
High Blood Pressure	Yes	No	Controlled with Medication or Diet
Cardiovascular	Yes	No	Heart Attack Angina Arrhythmia Congestive Failure MVP Chest Pain Shortness of Breath Swelling of Feet / Legs
Neurology	Yes	No	Stroke Seizures Migraine Neuropathy Alzheimer's Bells Palsy Mini Stroke Parkinson's Dizziness Headaches Tremors MS
Endocrine	Yes	No	Thyroid PCOS Menopause Diabetes How Long _____ Last HbA1C _____ Last Blood Sugar _____ Pituitary Excess Thirst Excessive Urination
Pulmonary	Yes	No	Asthma Emphysema Edema COPD Sleep Apnea C - PAP Used Tuberculosis Pneumonia Bronchitis Wheezing Coughing Shortness of Breath
Genitourinary	Yes	No	Prostate Kidney Disease Kidney Stones UTI Dialysis Ovarian Pain / Burning with Urination Blood in Urine
Gastroenterology	Yes	No	GERD-reflux IBS Ulcers Hiatal Hernia Diverticulitis Liver / Gallbladder Pancreatitis Crohn's Diarrhea Abdominal Pain
Hematology	Yes	No	Anemia Hepatitis High Cholesterol HIV Phlebitis Sickle Cell Disease Lyme Disease Easy Bruising Prolonged Bleeding
Rheumatology / Skeletal	Yes	No	Degenerative Arthritis Rheumatoid Arthritis Sjogren's Syndrome Gout Osteoporosis Joint Pain Lupus Sarcoidosis
Psychiatry	Yes	No	Depression Anxiety Bipolar ADHD Schizophrenia Other: _____
Cancer	Yes	No	Skin Breast Prostate Lung Leukemia Other: _____
Integumentary	Yes	No	Lupus Shingles Rosacea Psoriasis Eczema Rash Change in Mole
Constitutional	Yes	No	Weight Gain Weight Loss Fatigue Loss of Appetite
HENT	Yes	No	Hearing Loss Sinusitis Sore Throat Dry Mouth
Developmental	Yes	No	Prematurity Intellectual Disability Other:

Surgical History	Bypass - CABG	Heart Stent	Hernia-Herniorrhaphy
	Tonsillectomy	Prostatectomy	Hysterectomy
	Gallbladder-Cholecystectomy		Appendectomy

Other: _____

OVER

Medications - Please provide list if additional space is needed. ALL Medications Including Eye Drops & Eye Medications

Medication	Strength	Frequency	Medication	Strength	Frequency
			AREDS 2		
			Artificial Tears		
High Ocular Risk Medications	Plaquenil Cialis	Sabril Viagra	Systemic Steroids Thioridazine	Amiodarone	Flomax Tamoxifen

Allergies To Medications _____ **No Known Drug Allergies**

Most Common Medication Allergies:	Penicillin	Sulfa	Codeine	Neomycin	NSAIDS	Aspirin
Other Medication:						
Symptoms:						

Ocular History

	Right Eye	Left Eye
Cataracts		
Macular Degeneration		
Glaucoma		
Strabismus / Amblyopia		
Diabetic Retinopathy		
Iritis		
Blepharitis / Dry Eyes		
Melanoma		
Epi - Retinal Membrane / Pucker		
Injury to Eye(s)		
Last Exam Date		

Ocular Surgery History

	Right Eye	Left Eye	Surgeon & Date
Retinal Detachment / Tear			
Cataract Surgery			
Glaucoma Surgery			
Injections			
Eye Muscle			
Lasik / PRK / RK			
Diabetic Laser			
YAG (After Cataract)			
Punctal Plugs			
Corneal			
EyeLid			

Social History

Do you Smoke	Never Smoked	Every Day	Occasional/Social	Former
Do you drink Alcohol	None	1 or 2 Drinks Per Day	Occasional/Social	
Do you have a history of substance abuse	No	Yes	Please explain _____	

Hobbies

Hunting	Fishing	Golf	Cross-Stich	Sewing	Reading
Video games	Number of hours using video devices a day? _____				
Other:	_____				

Family History

Please list the family member for any disease or problem you select

Macular Degeneration _____	Retinal Detachment _____	Glaucoma _____	Optic Nerve Disease _____
Cataracts _____	Strabismus (Eye Muscle) _____	Amblyopia (Weak Vision) _____	
Cancer _____	Diabetes _____	Kidney Disease _____	Adopted _____
High Blood Pressure _____	Heart Disease _____	Lung Disease _____	Rheumatoid Arthritis _____

If wearing contacts:

	Right Eye	Left Eye
Daily Wear (take out at night)		
Extended Wear (sleep with on)		
Astigmatism		
Multifocal		
Other		
Hours a day worn		
Replacement Schedule	Right Eye	Left Eye
One Day		
Two Weeks		
Monthly		
Yearly		
Other		
Solution used		

Contact Symptoms

	Right Eye	Left Eye	How long
Blurring			
Build Up			
Discomfort			
Itching			
Burning			
Stinging			
Corneal Ulcer History			
End of Day Dryness			

Current Brand of Contacts _____
Interested in Daily Contacts _____

Solution Allergy / Sensitivity Brand(s) _____

Reviewed By: Dr. Keith Sparkman O.D.
Signature: _____
Date _____