Thank you for being or becoming a patient of **Corneal Consultants of Colorado** and **Colorado Eye Consultants**.

Please indicate any changes from the LAST visit.

Name: _____ **Date of Birth:** _____

Today's Date: _____ Primary Care Physician: _____ Ph #: _____

Eye Doctor (outside CCC): _____ Ph #: _____

Doctor who Referred you to CCC: _____ Ph #: _____

What is the reason for your visit today? _____

Past/Current Medical History: Please check if you have any of the following conditions

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Irregular heartbeat
- ☐ Bone Marrow Transplant
- ☐ Breathing problems
- ☐ Cancer of any kind
- ☐ Heart disease
- ☐ Depression
- ☐ Diabetes (Age at onset ___ yrs.)
  Endocrinologist: _____
- ☐ Kidney disease
- ☐ Acid Reflux
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke

Past Surgeries: Please list types and dates of all surgeries

_____ _____ _____

_____ _____ _____

_____ _____ _____

Eye History: Please check and note if involving your right eye, left eye, or both eyes

- ☐ Pink eye
- ☐ Inflamed eyelids
- ☐ Cataract(s) ☐R ☐L ☐B
- ☐ Contact lenses
- ☐ Corneal dystrophy ☐R ☐L ☐B
- ☐ Diabetic retinopathy
- ☐ Dry eye(s)
- ☐ Glasses
- ☐ Glaucoma ☐R ☐L ☐B
- ☐ Macular degen ☐R ☐L ☐B
- ☐ Narrow angles ☐R ☐L ☐B
- ☐ Ocular Hypertension ☐R ☐L ☐B
- ☐ Ocular migraine
- ☐ Retinal Tear ☐R ☐L ☐B
- ☐ Strabismus ☐R ☐L ☐B
- ☐ Floaters ☐R ☐L ☐B
- ☐ Other _____

Eye Surgery: Please check all that apply

- ☐ Blepharoplasty ☐R ☐L ☐B
- ☐ Cataract surgery ☐R ☐L ☐B
- ☐ Corneal transplant ☐R ☐L ☐B
- ☐ Eye injections ☐R ☐L ☐B
- ☐ Lasik/PRK ☐R ☐L ☐B
- ☐ Laser - narrow angles ☐R ☐L ☐B
- ☐ Laser - open angles ☐R ☐L ☐B
- ☐ Ptosis repair ☐R ☐L ☐B
- ☐ YAG Laser capsulotomy ☐R ☐L ☐B
- ☐ Punctal plugs ☐R ☐L ☐B
- ☐ Retinal laser ☐R ☐L ☐B
- ☐ Other: _____

Family History: Please check all that apply and indicate relationship (i.e. mother, father, sibling)

- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Macular degeneration _____
- ☐ Migraines _____
- ☐ Retinal detachment _____
- ☐ Strabismus _____

Medications: Please list all medication you take regularly - please use additional pages if necessary

Please complete the reverse side of this form.

Allergies: Please list all allergies

Demographic Information: Required to receive Federal funding

		☐ I decline to provide
Preferred language:	☐ English	☐ Other
Gender:	☐ Male	☐ Female
Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino
Race	☐ American Indian or Native Alaskan	☐ Black/African American
	☐ Native Hawaiian or Pacific islander	☐ White
	☐ Asian	☐ Other
Smoking status:	☐ Current everyday smoker	☐ Never smoker
	☐ Current some day smoker	☐ Unknown
	☐ Former smoker	☐ Light smoker
	☐ Smoker, current status unknown	☐ Heavy smoker

Acknowledgement of Notice of Privacy Practices (HIPAA) - Please check to acknowledge agreement

☐ I acknowledge that Corneal Consultants of Colorado/Colorado Eye Consultants *Notice of Privacy Practices* was made available to me.

Assignment of Benefits and Choice of Type of Insurance Used - Please check to acknowledge agreement

☐ I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my call cellular and landline devices using automated dialing systems.

Choice of Insurance - Vision or Medical (Determined at completion of your visit)

☐ **Vision Eye Examination** - You must have a VISION INSURANCE benefit (i.e., VSP, EyeMed, Davis, or Spectera) to use this type of insurance. **A vision eye examination is performed when there is NO underlying medical condition other than simple changes in your vision that can be corrected using glasses or contact lenses.** ***Many vision insurances will pay for fees associated with receiving a***

☐ **Medical Eye Examination** - You must have a MEDICAL INSURANCE benefit that covers your eye care. These examinations are for the diagnosis and treatment of eye diseases. Medicare, Medicaid and many other insurances will NOT reimburse CCC/CEC for the cost of the refraction, so if you are here for a MEDICAL EXAMINATION and you would like to receive a new or revised eyeglass prescription, ***you will be required to pay $45 when you check out today. By checking this box, you consent to pay this fee. You will receive a printed copy of your prescription at the time of your check-out today.***

☐ **I do not want a refraction today**

☐ **I do not have Vision or Medical Insurance** - I agree to pay ALL costs associated with today's visit following my visit today.

Print Name	Sign Name	Date
Print Name of Parent/Guardian	Sign Name of Parent/Guardian	Date

Please retain and give to your technician once this form is complete.

Patient HIPAA Compliance Form

COLORADO
EYE CONSULTANTS

Our Notice of Privacy Practice provides information about how we use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

May we phone, email, or send a text to you to confirm appointments? YES____ NO _____

May we leave a message on your answering machine/voicemail

at home or on your cell phone? YES ____ NO _____

May we discuss your medical condition with anyone other than you? YES____ NO _____

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____