

WELCOME

Denise Carter, O.D. * Optometry and Contact Lenses
Please Print and Fill Out Completely

Name: _____ Date: _____ SSN _____
 First Middle Last

Address _____ City _____ State _____ Zip _____

Age: _____ Birth date _____ Home Phone: _____ Work Phone: _____

Circle One: Minor Married Divorced Widowed Single Separated

If Minor, name of parent or guardian: _____

Your Employer _____ Occupation _____

Insurance Company (if any): _____ Name of insured: _____ D.O.B.: _____

How did you hear about us? Please circle: Radio Newspaper Yellow pages Other

Who were you referred by: _____

Do you prefer to get your reminder to schedule your next exam, via post-card or e-mail? (Please circle)
E-mail address: _____

HEALTH HISTORY

Please list ALL medications you are currently taking: _____

Name of previous eye doctor: _____ Date of last exam: _____

Do you or anyone in your immediate family have a history of the following:

Blindness Cataracts Diabetes Glaucoma Heart Condition High Blood pressure Macular Degeneration Thyroid Turned or "lazy" Eye

List any allergies you have: _____

Have you ever had any of the following conditions involving your eyes?

Eye surgery Sensitivity to Light Eye infection or disease Eye injury Floaters or Spot Eye Strain
Double Vision Medical Treatment Poor Distant or Near Vision Severe Pain Eyes Burn, Itch or Water

Do you currently wear glasses: Yes No

When do you wear your glasses?

All the time Reading/Near work Work Safety Distance Tasks Only Computer work Other:

Have you ever worn contacts? Yes No

Are you interested in wearing contacts lenses? Yes No

Do you work at a computer or video display terminal? Yes No

What hobbies or sports do you participate in? _____

PAYMENT DUE AT TIME OF SERVICES, PLEASE

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I hereby authorize Dr Denise W. Carter to furnish information to insurance carriers concerning my condition, and I hereby assign to Dr. Carter all payments for medical services rendered to myself or to my dependents.

Date: _____ Signature _____

Social History

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

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you 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

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	NO	YES	?
CONSTITUTIONAL						
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
NEUROLOGICAL						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EYES						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENDOCRINE						
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
				EARS, NOSE, MOUTH, THROAT		
				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
				Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
				RESPIRATORY		
				Asthma	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
				VASCULAR / CARDIOVASCULAR		
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
				GASTROINTESTINAL		
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>
				GENITOURINARY		
				Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
				BONES / JOINTS / MUSCLES		
				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
				LYMPHATIC / HEMATOLOGIC		
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
				ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature

Date

Receipt of Notice of Privacy Policies & Consent Form

Denise W. Carter, O.D.
1264 Ribaut Rd, Suite 302
Beaufort, SC 29902
(843) 525-0166

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Denise W. Carter, O.D.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____