McCLANAHAN EYE CARE

DATE: ___/___/___

NAME: ______________________________ AGE:__________ DOB: ___/___/_____

ADDRESS: ______________________CITY: _____________ STATE: ___ ZIP: _____

HOME PHONE: _____________________ CELL PHONE: ______________________

EMAIL____

EMPLOYER: _____________________________ ADDRESS: ___________________

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SS# : ______________________________

NAME OF PRIMARY (the person who carries the insurance)
INSURED:_____________________________DOB__________SSN________________

Primary Care or Endocrinologist if Diabetic
Physcian___________________________________ADDRESS_____________________

SPOUSE/GUARDIAN NAME: ____

EMERGENCY CONTACT: _____________________ RELATIONSHIP:________

HOME PHONE: __________________________ WORK PHONE: _______________

How did you hear about us:
Relative____Friend____Phone____Directory____Internet____Other________________

Patient/Guardian Signature____

If Guardian please print name and relationship to patient__________________________

For office use ONLY

Patient information verified by staff member __________________________Date_________________

Patient information verified by staff member __________________________Date_________________

Patient information verified by staff member __________________________Date_________________

AUTHORIZATION RELEASE TO PAY BENEFITS TO PHYSICIAN

I hereby authorize release of any medical information necessary to process this claim and all future claims. I further request that payments of assigned benefits be made to DR. McClanahan/McClanahan Eye Care. **I understand that I am financially responsible for all charges whether, not paid or denied by said insurance**. A copy of this statement shall remain on file until revoked by me in writing.

PATIENT NAME
Please Print ____

If under 18 Guardian Name____

Signature____________________________________Date____________

Signature____________________________________Date____________

Signature____________________________________Date____________

Signature____________________________________Date____________

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996 (HIPAA).

The patient understands the following:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

This Consent was signed by:____

Printed Name of Patient or Representative:______________________________________

Relationship to Patient (if other than patient):____________________________________

Date:________________________________

In front of Practice Representative:____

McClanahan Eye Care, 130 Hospital Drive, Winchester, Ky. 40391

McClanahan Eye Care

Medical History Questionnaire

Name____Date________________________

Date of last eye exam____________Where was exam____

Do you currently wear Glasses? Yes No Do you currently wear Contacts? Yes No
If Yes, how long have you worn your current prescription?_________

List any Medications you are currently taking (prescription and over-the-counter)

____

____

____

Do you have any **allergies** to medications? Yes No If yes, please list________________________________
Latex Allergy? Yes No Have you ever had a blood transfusion? YES NO

List any **surgeries** you have had: cataract lasik tonsillectomy appendectomy heart Other___________
____**None**_____

List **major illnesses**: glaucoma diabetes I diabetes II high blood pressure heart attack stroke cancer
Rheumatoid arthritis Lupus Multiple Sclerosis HIV Other______________________________**None**______

Please mark yes or no for all of the following eye health problems. If yes, please provide date symptoms began.

Loss of vision	YES	_________	NO	Foreign body sensation	YES	_________	NO
Blurred vision	YES	_________	NO	Excess tearing/watering	YES	_________	NO
Distorted vision	YES	_________	NO	Glare/light sensitivity	YES	_________	NO
Loss of side vision	YES	_________	NO	Eye pain or soreness	YES	_________	NO
Double vision	YES	_________	NO	Tired Eyes	YES	_________	NO
Fluctuating vision	YES	_________	NO	Crossed or lazy eyes	YES	_________	NO
Dryness	YES	_________	NO	Redness	YES	_________	NO
Itching	YES	_________	NO	Drooping eyelid	YES	_________	NO
Burning	YES	_________	NO	Mucous discharge	YES	_________	NO
Sandy/gritty feeling	YES	_________	NO	Infection of eye or lid	YES	_________	NO

Other__________________

Please mark anyone in your immediate family who has any of the following conditions.

Glaucoma	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Blindness	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Cataracts	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Cancer	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Diabetes	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Heart Disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
High blood pressure	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Kidney disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Lupus	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Stroke	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Thyroid disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle

None of the above

Please check any following general health conditions and give date condition began.

GENERAL/CONSTITUTIONAL	Fever ______________Weight Loss _____________ Other ___________________________
EARS NOSE THROAT	Sinus ______________Ear Infection ___________ Chronic Cough_________Other ______
CARDIOVASCULAR	Heart________________Vessels___________Other____________________________________
RESPIRATORY	Asthma________Emphysema___________COPD____________Other___________________
GASTROINTESTINAL	Stomach ulcers_________________Intestinal Disease______________Other______________
GENITAL, KIDNEY, BLADDER	____
MUSCLES, BONES, JOINTS	Arthritis___________________________Other_______________________________________
SKIN	Acne__________Warts__________Skin Cancer_____________Other____________________
NEUROLOGICAL	Multiple Sclerosis____________________Other______________________________________
PSYCHIATRIC	Anxiety_________Depression___________Insomnia__________Other___________________
ENDOCRINE	Diabetes________ Hyperthroidism_________Other_____________________________________
BLOOD/LYMPH	Anemia_________Cholesterolemia_________Other____________________________________
ALLERGIC/IMMUNOLOGIC	Hayfever________Lupus__________Sjogrens____________Other______________________

None of the above_________

SOCIAL HISTORY

Please circle YES or NO for the following questions and answer where applicable.

Current Occupation: ___________________________________ Do you live alone? YES NO

Education: Grade school High school Vocational school College

Do you drive? YES NO Do you have problems with night vision? YES NO

Do you drink alcohol? YES NO If Yes: Occasional 1/day 2-3/day 4 or more/day
Do you smoke? YES NO If Yes: Occasional ½ pack/day 1 pack/day 1 or more packs/day

Office Use ONLY---

Physician's Signature____________________ History reviewed_________ Additions as noted above________ Date______________
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MCCLANAHAN EYE CARE

We have incorporated into our practice the **CIRRUS HD-OCT LASER SPECTROMETER,** a highly sophisticated, computerized instrument that helps with **early detection of glaucoma**.

Glaucoma is a major health problem. It is a leading cause of blindness in the United States, but over a million Americans have it and don't know it. To treat glaucoma most effectively, it is important to find it as early as possible.

Therefore, the Doctors of MCCLANAHAN EYE CARE highly recommend a convenient screening test to help him/her determine which patients may need a full glaucoma examination. This maximizes our chances of finding glaucoma as early as possible.

The CIRRUS HD-OCT screening exam

The screening Exam is quick, comfortable and does not require dilation. It will measure the retinal nerve fiber layer in the back of the eye, which is often where the first signs of glaucoma appear. Please note that glaucoma screening tests are not covered by insurance.

We strongly recommend the CIRRUS HD-OCT screening exam if you have:

- Family history of glaucoma
- African-American or Latino ancestry
- High eye pressure (IOP)

We also highly recommend the CIRRUS HD-OCT screening exam if you are:

- Age 20-29 and have never had an eye exam
- Age 30-39 and it has been over 5 years since the last complete eye exam
- Age 40-64 and it has been over 2 years since the last complete eye exam
- Age 65 or older and it has been over 1 year since the last complete eye exam

Please check the appropriate line below and sign at the bottom.

_____I **DO** want the OCT screening exam, and agree to **the additional charge of $25.00 not covered by insurance.**

_____**I DO NOT** want the OCT screening exam

PATIENT'S SIGNATURE:____________________________DATE:______________