McCarthy Eye Center

Patient Name: (First, Last)			
Gender: Female Mal	e Other		
Address:			
Apt:	_		
City:	State:	Zip Code:	
Date of Birth:		Social Security:	
Single: Married: C	Other:		
Altomata Dhana			
Email Address:			
Primary Care/Pedia	trician /Sut	specialty Informati	<b>on</b> •
	•		
Name:			
Address:			
City/Zip Code:			

Please briefly explain the reason for your visit:

Last Eye Exam: \_\_\_\_\_

Eye drops: Please list all over the counter and prescription eye drops you use.

## Visual History:

Do you wear eye glasses?YDo you wear contacts?YDo you have dry eyes?YDo you experience; itchy/burning/tearing?YHave you ever been diagnosed with glaucoma?YHave you ever had Lasik Eye Surgery?YHave you ever had any laser eye treatments?YHave you been told you have cataracts?YHave you ever had cataract surgery?YHave you ever had noy laser eye treatments?YHave you ever had ony laser eye treatments?YHave you ever had cataract surgery?YHave you ever had cataract surgery?YHave you experienced double vision?YHave you experienced any eye injuries?Y

Y	N
Y	N
Y	N
Y	Ν
Y	N
Y	N
Y	Ν
Y	N
Y	N
Y	N
Y	N

McCarthy Eye Center

Have you ever had surgery?	Y	Ν
Are you pregnant or currently nursing?	Y	N

# Medical History:

High Blood Pressure	Y	N
Thyroid Disease	Y	N
•	Y	N N
Diabetes	Type:	11
Arthritis	Y	N
Neurological Disorder	Y	N
Asthma	Y	N
High Cholesterol	Y	Ν
Heart Disease	Y	N
Bleeding Disorder	Y	N
Autoimmune Disease	Y	N
Cancer	Y	N

## Medications/Vitamins/Eye drops:

Please list all current medications and vitamins; include milligrams if applicable and over the counter meds/vitamins.

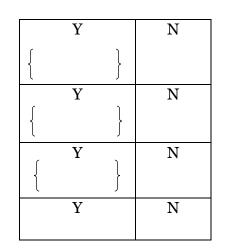
#### Allergies:

## Family Vision/Medical History:

Glaucoma	Y / who:	N
Blindness	Y / who:	N
High Blood Pressure	Y / who:	Ν
Thyroid	Y / who:	Ν
Autoimmune Disease	Y / who:	N
Heart Disease	Y / who:	N
Stroke	Y / who:	N
Diabetes	Y / who:	N

#### Social History:

Do you currently smoke? If yes, how much/often? Have you ever smoked? If yes, when did you quit? Do you drink alcohol? If yes, how much? Do you use recreational drugs



#### FEE POLICIES FOR MCCARTHY EYE CENTER:

<u>All fees pertaining to your office visit will be billed to your insurance company. Any annual deductibles are/or copayments are your responsibility and should be paid at the time of your visit. There is a refraction fee to get a prescription for glasses or contacts.</u>

I understand that I will be held responsible for any deductibles/copayments or non-covered services by my insurance. If my account goes without payment for 90-120 days, I understand that my account will be sent to a collection agency and I will be responsible for paying an additional 30% off the fee. I understand that if I wish to get a new prescription, I will be responsible for a refraction fee if not covered by my insurance.

#### Consent for Medical Care and Release of Medical Records:

I give my permission for medical care, including the recording of my medical history, physical examination, laboratory tests, and x-ray films; any of which may help evaluate my condition, plan treatment, or evaluate its results. I have been informed that written and computerized records regarding my illness, treatment, follow-up will be kept by my doctors and their staff. I also understand that computer access to and/or copies of these records which may include pathology slides, x-ray and associated reports may be provided to authorize personnel at affiliated institutions where I may continue my treatment. If I wish to get a copy of my medical records, I am aware of a fee. I am aware of the fact that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me in terms of treatment of examination. My medical records may be used by McCarthy Eye Center, S.C. and/or my insurance carrier for auditing as well as billing purposes to improve the efficiency and quality of healthcare.

I am aware my pupils may need to be dilated as part of my eye examination and that I may or may not be able to drive immediately following my exam.

By signing below, I have read and understood the Fee Policies/Medical Care and Release of Medical Records.

#### ACKOWLEDGEMENT OF RECEIPT McCarthy Eye Center, S.C.

Notice of Privacy Practices by signing below you acknowledge that you have received a copy of our Notice of Privacy Practices.

\*Signature:

Date:

Relation to patient (if not self):

# **Pharmacy Information**

Prescriptions will be sent electronically. Please fill out as best you can.

Pharmacy name:		
Pharmacy Address:		
City:	_	
Zip Code:		
Pharmacy is crossing the streets of:		
Pharmacy Phone Number:		
*** Only for patients under the age of 18*** Height:		
Weight:		