WELCOME TO

CENTRAL OREGON EYECARE

PATIENT NAME (LAST, FIRST, MIDDLE) _____ PREFERRED NAME IF DIFFERENT _____

PARENT/GUARDIAN NAME (LAST, FIRST, MIDDLE) _____ RELATIONSHIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS (IF DIFFERENT) _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ DRIVER'S LICENSE _____

EMPLOYER _____ OCCUPATION _____

FAMILY MEMBERS:

NAME _____ DATE OF BIRTH _____ SEX _____ RELATIONSHIP _____

NAME _____ DATE OF BIRTH _____ SEX _____ RELATIONSHIP _____

INSURANCE INFORMATION:

VISION INSURANCE _____ POLICY # _____ GROUP # _____

MEDICAL INSURANCE _____ POLICY # _____ GROUP # _____

PRIMARY CARE PROVIDER _____ LAST MEDICAL EXAM _____ LAST VISION EXAM _____ BY WHOM? _____

CONTACT LENS TYPE _____ AGE OF LENSES _____

REFERRED BY: YELLOW PAGES:____ RADIO AD:____ INTERNET:____ SIGN:____ DR:____

CETS:____ COUPON: ____ WALK-IN:____ DRIVE-BY:____ FAMILY:____ FRIEND:____

SIGNATURE _____ DATE _____

THANK YOU FOR SELECTING OUR EYE HEALTH TEAM! WE STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE EYE CARE. TO HELP US MEET ALL OF YOUR NEEDS, PLEASE COMPLETE THE INFORMATION LISTED ABOVE. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK US AND WE WILL BE HAPPY TO HELP YOU!

TODD M. SHELDOM OD, MBA, FAAO

DERRI SANDBERG, OD

CENTRAL OREGON EYECARE
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

ALLERGIES: NONE/ _____

MEDICATIONS: (INCLUDING ORAL CONTRACEPTIVES, ASPIRIN, OVER-THE-COUNTER, AND HOME REMEDIES) _____

LIST ALL MAJOR INJURIES, SURGERIES AND/OR HOSPITALIZATIONS: _____

ARE YOU PREGNANT AND/OR NURSING?: YES NO

DO YOU CURRENTLY WEAR GLASSES?: YES NO HOW OLD ARE THEY?: _____

DO YOU CURRENTLY WEAR CONTACTS?: YES NO RIGID OR SOFT

WHAT BRAND?: _____

SOCIAL HISTORY:

THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER, YOU MAY DISCUSS THIS PORTION WITH THE DOCTOR IF YOU PREFER.

DO YOU DRIVE? NO YES IF YES, DO YOU HAVE DIFFICUTLY WITH NIGHT VISION? NO YES

DO YOU USE TOBACCO/ALCOHOL/DRUGS? NO YES;

TYPE/AMOUNT/HOW LONG?: _____

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH:

GONORRHEA HEPATITIS HIV SYPHILIS

REVIEW OF SYSTEMS:

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD ANY PROBLEM IN THE FOLLOWING AREAS?:

EYES (Including Family):			EAR/NOSE/MOUTH/THROAT:	YES	NO
Retinal Problems	YES	NO	RESPIRATORY:	YES	NO
Cataracts	YES	NO	VASCULAR/CARDIOVASCULAR:		
Loss of vision	YES	NO	Diabetes	YES	NO
Blurred vision	YES	NO	HTN/HBP	YES	NO
Distorted Vision/Halos	YES	NO	GASTROINTESTINAL:	YES	NO
Loss of side vision	YES	NO	GENITOURINARY:	YES	NO
Double vision	YES	NO	BONES/JOINTS/MUSCLES:	YES	NO
Mucous discharge	YES	NO	LYMPHATIC.HEMATOLOGIC:	YES	NO
Redness	YES	NO	ALLERGIC/IMMUNOLOGIC:	YES	NO
Glare/light sensitivity	YES	NO	PSYCHIATRIC:	YES	NO
Chronic eye/lid infections	YES	NO	CONSTITUTIONAL:	YES	NO
Flashes/floaters	YES	NO	INTEGUMENTARY (SKIN):	YES	NO
Tired eyes	YES	NO	NEUROLOGICAL:		
Eye turn/lazy eye	YES	NO	Headaches	YES	NO
Macular degeneration	YES	NO	Migraines	YES	NO

DRY-EYE INFORMATION:

DO YOUR EYES EVER FEEL OR DO YOU EXPERIENCE:

Burning or itching?:	NEVER	SLIGHT	MODERATE	SEVERE
Gritty or sandy sensation?:	NEVER	SLIGHT	MODERATE	SEVERE
Pain or soreness?:	NEVER	SLIGHT	MODERATE	SEVERE
Fluctuating vision?:	NEVER	SLIGHT	MODERATE	SEVERE
Occasional tearing?:	NEVER	SLIGHT	MODERATE	SEVERE
Blurred vision while reading?:	NEVER	SLIGHT	MODERATE	SEVERE
Discomfort in windy conditions?:	NEVER	SLIGHT	MODERATE	SEVERE
Discomfort in air conditioned areas?:	NEVER	SLIGHT	MODERATE	SEVERE

DO YOU EVER SUFFER FROM RED, ITCHY, WATERY EYES, OR SWOLLEN EYE LIDS?: YES NO

DO YOU USE AN OVER-THE-COUNTER OR PRESCRIBED EYE DROP FOR ABOVE CONDTIONS? YES NO

DO YOU TAKE ANY PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS LIKE:

CLARITIN, ALLEGRA, ZYRTEC, ETC. YES NO

PATIENT SIGNATURE/DATE: _____

DOCTOR SIGNATURE/DATE: _____

NOTES: _____

ACKNOWLEDGMENT & CONSENT

I _____ understand that Central Oregon Eyecare, PC (referred to as "The Practice") will use and disclose **Health Information** about me.

I understand that my **health information** may include information both created and received by this practice, may be in the form of written or electronic records or spoken works, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this practice may **use and disclose** my health information in order to:

* Make decisions about and plan for my care and treatment;
* Remind me of appointments;
* Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
* Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
* Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other personnel of this practice, and my rights regarding my health information.

I understand that this Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of this practice's Notice of Privacy Practices will be posted in the waiting/reception area.

I understand that I have the right to ask that if some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices is not required by law to agree to such requests.

BY: _____ **DATE:** _____

(PATIENT)

BY: _____ **DATE:** _____

(PARENT/GUARDIAN IF APPLICABLE)

Financial Policy

Thank you for choosing Central Oregon Eyecare for your eye health needs. At Central Oregon Eyecare, we do our best to exceed your expectations in a friendly, efficient manner. We appreciate your trust in us.

As a courtesy, we attempt to verify your insurance benefits from your carrier, and bill your insurance company accordingly. Your co-pay, any deductibles not met, and non-covered services are expected at the time of service. Any prices quoted are estimates based on the information we received from your insurance.

In the event that your insurance denies coverage or applies any billed amounts to your deductible, the remaining charges will become your responsibility. By cooperating with this agreement, we will be able to continue offering service that meets the needs of all who trust us with their care.

If your insurance has not paid your claim within 60 days of filing, we will ask your assistance in contacting your insurance company. *Insurance balances not paid by your carrier within 90 days will become your responsibility.*

We understand that occasionally you need to change an appointment with us. As a courtesy, we ask that you give us at least 24 hours notice if you need to cancel, or reschedule an appointment. Appointments cancelled, rescheduled or missed without 24 hours notice will be subject to a $35 missed appointment fee.

By signing this you acknowledge that you are financially responsible for all charges on your account, and hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize payments of insurance benefits directly to Central Oregon Eyecare.

_____ _____

Patient signature Date

_____ _____

Parent/Guardian signature Date