Patient Information

Today's Date: ____/____/_____

Name: _____

Birth date: ____/____/_____ Social Security #: _____

Email: _____

(email is used for appointment reminders, order updates, and occasional newsletters)

Home Address: _____

_____

Home Phone: _____ Cell#: _____ Work#: _____

Marital Status: _____ Occupation: _____ Employer: _____

Languages spoken: _____ Ethnicity: _____

How did you hear about our office? _____

Primary Doctor Name, phone and Fax: _____

Pharmacy and Location and phone number: _____

List all medications you take, dosages and frequency (including over-the-counter and home remedies):

_____

_____

Allergy to Medication, food, or other? **Yes / No** (if yes please list):

_____

List all major injuries, surgeries and hospitalizations (including eyes):

_____

Are you pregnant or nursing? **Yes / No**

Do you use or have you ever used tobacco products? **Yes / No**

If yes, type, amount, how long, or when you quit? _____

Do you drink alcohol? **Yes / No**

If yes, type, amount, and how often? _____

Do you use any other recreational drug? **Yes / No**

If yes, type, amount, and how often? _____

Do you wear glasses? **Yes / No** If yes, how old is your current pair? _____

Do you wear contact lenses? **Yes / No** If yes, how old is your current pair? _____

Type of contact lenses: (Circle) **Hard(RGP) / Soft / Toric / Sleep In / Monthly / Daily / 2 Week**

Brand: _____ Power: (right): _____ (left): _____

EYE CONDITIONS / PROBLEMS

Please list any eye conditions from this list, or any other, on the lines below, and list who has the condition:

(for example, Blurred Vision, Light Sensitivity, Double Vision, Dryness, Tearing, Redness, Sandy/Gritty Feeling, Itching, Glare/Halo, Eye Pain, Flashing lights, Floaters, Blindness, Cataracts, Crossed Eyes, Glaucoma, Loss of Vision, Keratoconus, Recurring Eye Infections, Macular Degeneration, Retinal Disease)

Eye Problem (list):	ME	Family Member	Relation to me
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

MEDICAL CONDITIONS

Please list any eye conditions from this list, or any other, on the lines below, and list who has the condition:

(for example, Diabetes, Allergies, Asthma, Anxiety/Depression, Claustrophobia, Auto Immune Disease, Arthritis, Skin conditions, Anemia, Bleeding Issues, Headaches/Migraines, Seizures, Kidney Disease, Cancer (Type), Heart Disease, High Blood Pressure, High Cholesterol, Thyroid Disease, Sleep Apnea, HIV/AIDS, Hepatitis, etc)

Medical Condition (list):	ME	Family Member	Relation to me
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Please list hobbies: _____

_____

Do you use electronics for extended periods of time? **Yes / No** If yes explain:

_____

_____

Financial Statement:

I will be responsible financially for any bill incurred on this patient for treatment including reasonable attorney's fees, collections fees, and court costs from all proceedings should I not pay this account in a timely manner. I/We hereby authorize Dr. Hendrickson, or any agency employed by him, to both receive and dispense information regarding my/our credit reference and account.

Finance charge is computed by a periodic rate of 1.85% monthly billing cycle, which is an annual percentage rate of 22%, applied to the previous balance after deducting all payments and credits during the billing cycle. To avoid finance charges, pay this account within 30 days of the billing/ insurance transfer date.

I understand that I am responsible for the entire amount of the professional fee, for any professional service provided by the doctor or staff, and that I am responsible for the insured and uninsured portion of the bill.

Notice of Privacy Practices Acknowledgement of Receipt:

I acknowledge that I was provided a copy of/read/and understood Clarity Eye Care's Notice of Privacy Practices.

By Signing Below, I acknowledge I have read this form in its entirety, filled this form out completely and accurately, and I have been provided the opportunity to ask any questions I may have.

Patient Signature: _____ Date: _____

(If patient is under age 18)

Guarantor's Name: _____ Date of Birth: _____

Relationship to Patient _____ Social Security#: _____

Home Phone #: _____ Cell#: _____

Address (if different from patient): _____

_____

Email (if different from patient): _____

Guarantor's Signature: _____ Date: _____

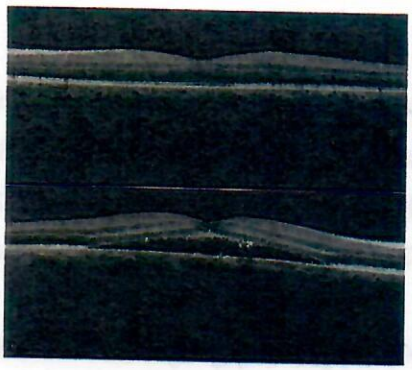
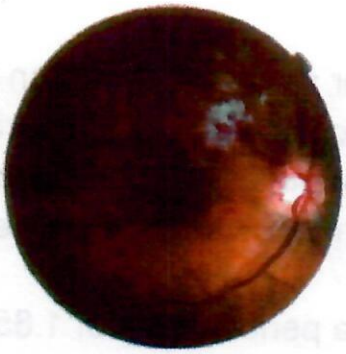
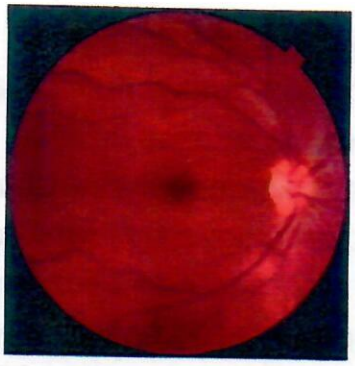
Witness: _____ Date: _____

For Clarity Eye Care use only. (Complete this section if this form is not signed and dated by patient or patient's representative.)

I have made a good faith effort to obtain a written acknowledgement of receipt of Clarity Eye Care's Notice of Privacy Practices but was unable to for the following reason: Patient refused to sign_____ Patient unable to sign_____ Other _____

Employee Name: _____

Signature: _____ Date _____

iWellness Exam + Digital Retinal Photography

Just as many other health professionals use MRI's, mammograms or X-rays to aid in diagnosing health conditions, our office provides a comparable level of quality care with the state-of-the-art iWellness® exam combined with digital retinal photos. The exam is quick, easy and comfortable and allows a detailed view of the inner lining of the eye often without the need of dilation.

Dr. Hendrickson recommends these detailed scans for every patient, as it allows for a powerful way to track subtle changes inside the eye that can otherwise go undetected.

Additionally, we strongly recommend the screening for patients with a personal or family history of high blood pressure, diabetes, macular degeneration, glaucoma, retinal holes, or detachments.

<u>The benefits</u>:

- **An enhanced, high-resolution digital cross-sectional scan and image of the blood vessels and the inner lining of the eye.**
- **The image becomes part of your permanent medical record allowing us to monitor for future changes.**
- **Facilitates the early diagnosis of many health conditions including high blood pressure, high cholesterol, diabetes, macular degeneration and glaucoma.**

Generally, insurance does not cover preventative care or the $39 fee of the iWellness® scan and routine retinal photos; as a result, *you will be responsible*.

Please select one: ✓

☐ **I agree to have the iWellness Exam + digital retinal photography and understand the <u>$39 fee</u>.**

☐ **I refuse to have digital retinal photography but understand its diagnostic importance**

Patient Signature_____ **Date:** _____

As always, Clarity Eye Care is dedicated to incorporating the latest technology to better serve you with the utmost quality of care and help to preserve your overall health and clarity of vision.