WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE CARDS TO RECEPTIONIST

Please Print

Patient's Legal Name: ______________________________

Marital Status ❑ M ❑ S ❑ D ❑ W

DOB ____/____/____ SSN# ____/____/____
Address ______________________________
City/St ______________________ Zip ________
Home Phone ______________________________
Cell Phone ______________________________
Occupation ______________________________
Email ______________________________

Primary Insured ______________________________
DOB ____/____/____
SSN# ____/____/____
Insurance Company ______________________________
Member ID# ______________________________

Miscellaneous

Last Eye Exam ____/____/____

Are you followed by an Ophthalmologist? If so, Whom? ____________	❑ Yes	❑ No
Do you wear glasses?	❑ Yes	❑ No
*Do you wear contact lenses?	❑ Yes	❑ No
*Are you interested in contact lenses?	❑ Yes	❑ No

*Additional fee for evaluation

Are there any specific optical products/brands that you are interested in?	❑ Yes	❑ No
Are you interested in refractive surgery?	❑ Yes	❑ No
Do you have trouble reading signs when driving at night?	❑ Yes	❑ No
Are you bothered by glare from: Overhead lighting?	❑ Yes	❑ No
A computer screen?	❑ Yes	❑ No
Oncoming headlights at night?	❑ Yes	❑ No
Are you sensitive in bright sunlight?	❑ Yes	❑ No
Are you Pregnant?	❑ Yes	❑ No
Are you Breastfeeding?	❑ Yes	❑ No

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

Condition	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Hearing Loss	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑
Gastrointestinal		
Crohn's Disease	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Ulcer/Reflux	❑	❑
Genito-Urinary		
Bladder/Genital/Kidney	❑	❑
Herpes Simplex	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint/Muscle Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Herpes Zoster/Shingles	❑	❑
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety/Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid/Other Glands	❑	❑
Lymphatic - Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic/Immunologic		
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑

Please Complete Both Pages of the Form →

Ocular History

Age-related macular degeneration	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Cataract Surgery	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
History of refractive surgery	❑ Yes	❑ No
Strabismus (Crossed eyes)	❑ Yes	❑ No
Tear film insufficiency (Dry eyes)	❑ Yes	❑ No

Other____

____

Family Health History

(Mark yes or no to each entry. If yes, list which family member including, mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather.

Amblyopia (Lazy eye)	❑ Yes	❑ No	____________
Blindness and/or vision impairment	❑ Yes	❑ No	____________
Cataract	❑ Yes	❑ No	____________
Macular Degeneration	❑ Yes	❑ No	____________
Glaucoma	❑ Yes	❑ No	____________
Retinal disorder	❑ Yes	❑ No	____________
Strabismus (Crossed eyes)	❑ Yes	❑ No	____________
Arthritis	❑ Yes	❑ No	____________
Cancer	❑ Yes	❑ No	____________
Diabetes	❑ Yes	❑ No	____________
Hypertension (High blood pressure)	❑ Yes	❑ No	____________
Cardiovascular disease	❑ Yes	❑ No	____________
Stroke	❑ Yes	❑ No	____________

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

- ❑ Will Discuss with Doctor
- ❑ Permission given to pull Medication List from Pharmacy
- ❑ Taking any over the counter medications
- ❑ No Prescribed Medications

Medication Allergies

List any allergies you may have:

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❑ **No Medication Allergies**

I hereby authorize KORRECT OPTICAL / SETH J SUMMERS, OD PSC to furnish information to insurance carriers on my behalf and I hereby assign to the doctor all payment for routine/medical services pertaining to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I understand that I am responsible for any fees or charges for services and/or materials. **Payment is requested at time of service. We accept cash, check, CareCredit™ and all major credit cards.**

Signature________________________________ Date____________________

Routine eye exams are typically not covered under your medical Insurance and therefore will need to be billed to a separate Vision Plan or paid in full at the time of service. Medical eye exams must be billed to your Health Insurance carrier. Any deductibles, refraction fees and co-pays will be billed to you.

Annual eye exams are vital to maintaining your vision and overall health. Dr. Summers and Dr. Reynolds offer the **opto**map® Retinal Exam as an important part of our eye exams. The **opto**map® Retinal Exam produces an image that is as unique as your fingerprint and provides the Doctors with a wide view look at the health of your retina. The retina is the part of your eye that captures the image of what you are looking at, similar to film in a camera.

Many eye problems can develop without you knowing. You may not even notice any change in your sight. Diseases such as macular degeneration, glaucoma, retinal tears or detachments, and other health problems such as diabetes and high blood pressure can be seen with a thorough exam of the retina.

An **opto**map® Retinal Exam provides:

- A scan to show a healthy eye or detect disease.
- A view of the retina, giving your doctor a more detailed view than he/she can get by other means.
- The opportunity for you to view and discuss the **opto**map® image of your eye with your doctor at the time of your exam.
- A permanent record for your file, which allows the Doctors to view your images each year to look for changes.

The **opto**map® Retinal Exam is fast, easy, and comfortable for all ages. To have the exam, you simply look into the device one eye at a time and you will see a soft flash of light to let you know the image of your retina has been taken. The **opto**map® image is shown immediately on a computer screen so we can review it with you.

I understand the benefits of the annual **opto**map® Retinal Exam as:

- Fast, easy and comfortable.
- A permanent record to compare and track potential eye diseases.
- An in depth view of nearly the entire retina.
- Educational tool for your doctor to discuss your health and wellness.

I understand that a wide field view of the retina is an important part of a comprehensive eye exam and that **I ACCEPT** the doctor's recommendation to obtain a comprehensive view of my retina for an additional fee of **$29.00** that I will be responsible for at the time of service.

Patient Signature ______________________________ Date ________________

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I,____, understand that as part of my health care, Optik by Korrect & Seth J. Summers, O.D., PSC, (Providers) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I understand that Providers are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that Providers reserve the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Providers change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health infomation:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses including disclosures via fax.

I understand that I must give written permission for Providers to disclose any information to my spouse or a family member. I hereby, give Providers permission to disclose my personal health information to:
List of names we can call

Name ____________________________________ Phone ________________________

Name ____________________________________ Phone ________________________

I fully understand and ☐ Accept ☐ Decline the terms of this consent

Patient Name (Please Print)____

Patient Signature____ Date____________