



# DURRIE VISION

See a dramatic difference.

**I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

**Are you eligible for Medicare coverage? Yes or No (please circle)**

**Are you covered by Medicare? Yes or No (please circle)**

## **Patient Agreement**

I understand that payment is due at the time of service. I certify that the information provided on all forms is correct. I authorize the release of medical information to Durrie Vision. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards. This agreement is in effect until revoked in writing by the patient.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

## **Health Insurance Portability and Accountability Act Waiver**

Because Durrie Vision is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, appointment times, prescriptions or any information contained in your records with us. Please list any persons or agencies that we have your permission to release your information to. (This information can be amended by you as needed.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Messages:**

I give my consent to the physicians and staff at Durrie Vision to leave messages or discuss scheduling, treatment, surgery, or other information regarding my care as follows:

- On answering machine or voice mail at home
- On answering machine or voice mail at work
- Cell Phone
- Email (email address listed above)
- I do not consent to messages being left at home work, email, or with any other person.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

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## Health History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Medication History

Please list all medications you are currently taking:

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Do you have a history of taking Flomax or similar medication for prostate issues?

Yes or No (please circle) \_\_\_\_\_

### Ocular History

Have you ever been diagnosed with any of the following eye problems? Yes or No, If so, please include which eye, using R for right eye, L for left eye, and B for both eyes.

\_\_\_\_\_ Amblyopia/Lazy Eye    \_\_\_\_\_ Dry Eye    \_\_\_\_\_ Iritis  
\_\_\_\_\_ Cataracts    \_\_\_\_\_ Fuch's Dystrophy    \_\_\_\_\_ Keratoconus  
\_\_\_\_\_ Corneal Scar    \_\_\_\_\_ Glaucoma    \_\_\_\_\_ Macular Degeneration  
\_\_\_\_\_ Diabetic Retinopathy    \_\_\_\_\_ Injury/Trauma    \_\_\_\_\_ Retinal Detachment/Tear  
Other \_\_\_\_\_

Have you had any eye surgeries? Yes or No (please circle)

| Surgery                          | Eye | Date | Doctor | Doctor's City/State |
|----------------------------------|-----|------|--------|---------------------|
| Cataract                         |     |      |        |                     |
| CK                               |     |      |        |                     |
| Corneal Transplant               |     |      |        |                     |
| Lasik                            |     |      |        |                     |
| Lid Surgery                      |     |      |        |                     |
| LTK                              |     |      |        |                     |
| PRK                              |     |      |        |                     |
| RK                               |     |      |        |                     |
| Retinal Detachment and/or Repair |     |      |        |                     |
| Strabismus/Muscle Surgery        |     |      |        |                     |
| Yag Laser                        |     |      |        |                     |
| Other                            |     |      |        |                     |

Continued on Back

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## Personal History

Have you ever been treated for any of the following medical conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anesthesia Complications         | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Muscular Dystrophy  |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Paraplegia          |
| <input type="checkbox"/> Back Problems                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Quadriplegia        |
| <input type="checkbox"/> Bipolar Disorder                 | <input type="checkbox"/> Hepatitis A or B or C | <input type="checkbox"/> Rosacea             |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Herpes Simplex        | <input type="checkbox"/> Seasonal Allergies  |
| <input type="checkbox"/> Cerebral Palsy                   | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Cervical Fracture                | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Diabetes (insulin dependent)     | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Diabetes (non-insulin dependent) | <input type="checkbox"/> Migraines             |  |

Do you currently have any of the following?

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Cochlear Implants | <input type="checkbox"/> Internal Defibrillator | <input type="checkbox"/> Pacemaker |
|--|---|------------------------------------|

Are you currently pregnant? Yes or No (please Circle)

Are you currently breastfeeding? Yes or No (please circle)

In the last 5 years, have you had any surgeries? Yes or No (please circle)

If so, please list and include date of surgery \_\_\_\_\_

## Patient Allergies

Please list all medications you are allergic to:

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to:

\_\_\_\_\_ Tape      \_\_\_\_\_ Latex      \_\_\_\_\_ Iodine/Betadine

## Family Medical History

Do any of your grandparents, parents, or siblings have any of the following?

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Adopted   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Retinal Detachment or Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Macular Degeneration |  |

## Social History

Do you drink? Yes or No (please circle) How Often? \_\_\_\_\_

Do you smoke? Yes or No (please circle) How Often? \_\_\_\_\_