Eyes bothering you?

Get to the bottom of what's going on.

What signs and symptoms have you experienced?

☐ Watery eyes ☐ Occasional blurry vision ☐ Burning ☐ Dryness ☐ Redness ☐ Stinging

☐ Irritation ☐ Grittiness ☐ Itchiness ☐ Other _____

My eyes bother me or become tired when I am:

☐ Wearing contacts ☐ Driving, especially at night ☐ Using screens (TV, computer, phone, tablet, etc.)

☐ Reading ☐ Traveling, especially on planes ☐ Other _____

I "feel" my eyes more than usual in places that are:

☐ Windy ☐ Bright ☐ Dry ☐ Smoky ☐ Air-conditioned ☐ Other _____

I've had:

☐ LASIK ☐ Cataract surgery ☐ Botulinum toxin injections ☐ An eye lift

I regularly apply:

☐ Eye makeup ☐ A prescription treatment to lengthen my eyelashes

I'm taking:

☐ Antihistamines ☐ Hormone replacement therapy ☐ Blood pressure medications

☐ Birth control pills ☐ Antidepressants or anti-anxiety medications ☐ Glaucoma medications

I use artificial tears: ☐ 1-2 times/day ☐ 3-4 times/day ☐ 5-6 times/day ☐ 7+ times/day

I've used artificial tears for: ☐ <1 year ☐ 1-5 years ☐ 5+ years

I've tried these artificial tears: _____

Checked off some boxes?

Give this to your health care provider and talk with your doctor about your selections above.

CHAMPION EYE CENTER **About Your Insurance**

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield, Cigna, Medcost and Medicare).

Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases such as glaucoma macular degeneration, corneal abrasions, dry eye, eye allergies, retinal floaters, eye injuries, pink eye and related medical eye conditions.

Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract. We will be happy to assist you with your claims; please give any forms to the receptionist.

I have read and agree with these policies.

_____ _____

Patient signature (parent if child) Date

Please provide your Vision and Medical Insurance cards to the receptionist upon arrival.

Do you have health insurance? ❑ Yes ❑ No

Name and ID number _____

CHAMPION EYE CENTER

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Notice: Be aware that anyone who accompanies you during your examination will hear your Private Health Information. By allowing this individual(s) to accompany you during your examination, you are giving us permission to disclose your Private Health Information to them. Images, sounds and conversations may be recorded.

I give the following individual(s) permission to receive my PHI (Private Health Information) today and anytime in the future. These individuals have my permission to call and inquire about my Private Health Information both verbally and written, unless I notify you in writing.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____

I, the Patient or the legal representative of the Patient, hereby authorize the release of any information to my insurance carriers and my referring physicians. I also authorize the payment of medical benefits directly to Champion Eye Center and I understand that I am responsible for any amount not covered by my insurance.

I, the Patient or the legal representative of the Patient, agree to provide payment in full for any insurance co-payments, co-insurance and/or deductibles. I am liable for [per my health insurance coverage] any office charges, if self pay, via cash, check or credit card on the date services are rendered.

_____ Date: _____

Printed Name - Patient or Representative

_____

Signature - Patient or Representative

_____ Date: _____

Signature - Mark Jacobs, OD., P.A., Employee

300 Julian Lane • Arden, NC 28704 • Phone: (828) 650-2727 • Fax: (252) 650-2725

PATIENT SOCIAL HISTORY

Do you drink alcohol? ❒ Yes ❒ No If yes, how often?_____ How much?_____

Do you smoke, or have you ever smoked? ❒ Yes ❒ No Year started _____ Year quit _____

What tobacco do you use? ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Chewing tobacco ❒ Snuff

Have you ever been exposed to or infected with? ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Do you use illegal drugs? ❒ Yes ❒ No If yes, type/amount/how long: _____

FAMILY MEDICAL HISTORY / Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU	DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	❒	❒		Cancer	❒	❒	
Cataract	❒	❒		Diabetes	❒	❒	
Crossed Eyes	❒	❒		Heart Disease	❒	❒	
Glaucoma	❒	❒		High Blood Pressure	❒	❒	
Macular Degeneration	❒	❒		Kidney Disease	❒	❒	
Retinal Detachment/Disease	❒	❒		Lupus	❒	❒	
Arthritis	❒	❒		Thyroid Disease	❒	❒	

Other: _____

REVIEW OF SYSTEMS / Do you currently have any problems in the following areas?

	YES	NO
Allergic/Immunologic	❒	❒
Bones/Joints/Muscles		
rheumatoid arthritis	❒	❒
muscle pain	❒	❒
joint pain	❒	❒
Constitutional		
fever, weight loss/gain	❒	❒
fatigue	❒	❒
thirst (excess)	❒	❒
urination (excess)	❒	❒
Ear, Nose, Mouth, Throat		
allergies/hay fever	❒	❒
sinus congestion	❒	❒
runny nose	❒	❒
post-nasal drip	❒	❒
chronic cough	❒	❒
dry throat/mouth	❒	❒

	YES	NO
Endocrine		
thyroid/other glands	❒	❒
kidney disease	❒	❒
cholesterol (high)	❒	❒
Gastrointestinal		
diarrhea	❒	❒
constipation	❒	❒
cancer: colon/liver	❒	❒
Genitourinary		
prostate	❒	❒
genitals/kidney/bladder	❒	❒
Integumentary (Skin)	❒	❒
Immunologic		
herpes simplex	❒	❒
HIV positive	❒	❒
lyme disease	❒	❒
sarcoidosis	❒	❒

	YES	NO
Lymphatic/Hematologic		
anemia	❒	❒
bleeding problems	❒	❒
sickle cell disease	❒	❒
Neurological		
headaches	❒	❒
migraines	❒	❒
seizures	❒	❒
Psychiatric		
mental illness	❒	❒
depression	❒	❒
Respiratory		
copd	❒	❒
asthma	❒	❒
chronic bronchitis	❒	❒
emphysema	❒	❒
Vascular/Cardiovascular		
heart pain	❒	❒
high blood pressure	❒	❒
vascular disease	❒	❒

WELCOME TO CHAMPION EYE CENTER — Medical History Questionnaire

Last Name: _____ Today's Date: _____

First Name: _____ Sex: ❒ male ❒ female

Address: _____ Date of Birth: _____

City: _____ Social Security: _____

State/Zip _____ Employer: _____

Day Time Phone: _____ Occupation: _____

Cell Phone: _____ Communication Preference: ❒ Telephone ❒ Email

Email: _____ Last Eye Exam: _____

Referred By: ❒ Patient ❒ Professional _____ Last Physical Exam: _____

Referred Name: _____ Primary Care Physician: _____

PATIENT MEDICAL HISTORY

Have you had eye or laser surgery before? ❒ yes ❒ no If yes, which eye was operated on? ❒ left ❒ right ❒ both

If yes, why were you operated on? _____

List medication allergies or none? _____

List all drugs you are currently taking? (eye drops, herbs & vitamins)

Name	Dose (mg)	How Often	Name	Dose (mg)	How Often

Are you diabetic? ❒ Yes ❒ No If yes, how long? _____

What was your blood sugar this morning? _____ What was your last Hemoglobin A1C (3 mo. avg. blood sugar)? _____

Do you wear glasses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ Yes ❒ No

Please describe your current eye problems: _____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Do you currently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO		YES	NO
flashes/floaters in vision	❒	❒	sandy or gritty feeling	❒	❒	loss of side vision	❒	❒	lazy eye	❒	❒
excess tearing/watering	❒	❒	foreign body sensation	❒	❒	itching	❒	❒	crossed eyes	❒	❒
dryness	❒	❒	chronic infection of eye or lid	❒	❒	sties or chalazion	❒	❒	drooping eyelid	❒	❒
burning	❒	❒	cataracts	❒	❒	glaucoma	❒	❒	eye injury	❒	❒