WELCOME TO H. RUBIN VISION CENTER 2014

NAME: _____ DATE_____

Street:_____ City_____ Zip_____

Home/Cell Phone:_____ W Phone_____ DOB_____

Occupation _____ Referred By_____ Last Exam_____

PLEASE CHECK WHICH CONDITION APPLIES TO YOU:

YOUR HEALTH HISTORY: ___ High blood pressure __ Diabetes - how long?___yrs ____ Strokes ____asthma
___ High cholesterol ___ Arthritis __ Heart problems ____ Heart attacks __ Pregnant
___ Migraines ___Hay fever/sinus __ Thyroid Disease ____ HIV +
___ Anxiety/depression ____Anemia __Other please list:_____

FAMILY HISTORY:
___ High blood pressure ____ Diabetes ____ Heart problems ____ Cancer ____ Blindness
____ Glaucoma ___ Macular disease _____Lazy eye _____ Other eye disease_____

ARE YOU TAKING ANY MEDICATIONS YES NO LIST_____

DO YOU USE EYE DROPS YES NO WHAT FOR_____

ARE YOU ALLERGIC TO ANY MEDICATIONS YES NO WHICH MEDS_____

PATIENT INFORMED CONSENT FOR PUPIL DILATION

I understand Dr. Spittler recommends ocular dilation for a more thoroughly evaluate the internal health of my eyes. It will typically take two hours for the effects to wear off. During this time reading ability may be more difficult and your sensitivity to light may increase. For a short time wearing sunglasses may be a necessary for comfort. Notify my staff if you feel your distance vision is excessively blurred before attempting to drive home. Thank you for your patience during this important procedure. Call my office immediately if you experience excessive pain, discomfort, or nausea. I agree to indemnify, hold harmless, and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions of Dr. Spittler, Orangeburg Optometric LLC and their employees, officers, directors or agents.

LIFETIME SIGNATURE ON FILE, AUTHORIZATION TO RELEASE INFORMATION/ASSIGN BENEFITS

I hereby authorize Orangeburg Optometric LLC to release any information obtained during the course of my evaluation and treatment which is necessary for the processing of insurance claims, disability statements, or documentation of services rendered. I hereby authorize payment of all applicable medical/vision insurance benefits for the services rendered by Orangeburg Optometric LLC directly to Orangeburg Optometric LLC. I understand and agree that I am responsible for all charges not paid in full by my health insurance carriers, including all applicable co-payments, deductibles and co-insurances amounts. I agree to pay all costs and reasonable fees in the event this account is turned over to a collection agency. I permit a copy of this authorization to be used in place of the original signature. This assignment shall remain in effect until revoked by me in writing.

Signature of Patient/Guardian_____ Date_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND REFUND POLICY

My signature below indicates that I have been offered or read a copy of the "Notice of Privacy Practices" and "Refund and Remake Policy" from Orangeburg Optometric LLC and agree to continue my care under said terms.

Signature of Patient/Guardain_____ Date_____/_____/_____

Present Rx: OD_____ CLRX: OD_____

OS_____ OS_____

Add_____ BC_____ Brand_____