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.

AUTHORIZATION TO RELEASE INFORMATION

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.

Signature of Patient/Guardian____________________ Date_____/_____/_____

AUTHORIZATION TO ASSIGN BENEFITS TO ORANGBURG OPTOMETRIC LLC

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 that I am responsible for all charges not paid in full by my health insurance carriers, including all applicable co-payments, deductibles and co-insurance amounts.

Signature of Patient/Guardian____________________ Date_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received a copy of the “Notice of Privacy Practices” from Orangeburg Optometric LLC.

Signature of Patient/Guardain____________________ Date_____/_____/_____

Present Rx: OD____________ CLRX: OD____________

OS____________ OS____________

Add________ BC______ Brand______