WELCOME TO OUR OFFICE - PLEASE PRINT

Dr. / Mr. / Mrs.
Ms. / Miss (circle one) ______________________________________________
First Name Middle Initial Last Name

Today's Date ____ /______ /________

Address__________________________________ Apt# __________

Sex: Male / Female Age_________

City _____________________State ___________Zip __________

Date of Birth ________/ _______/ ________

Home Phone ( ___ ) ______________________________________

Work Phone_______________________

Employed by ______________________________________________

Responsible Party____________________

Occupation_______________________________________________

Address __________________________

Date of last examination__________________________________

Patient's Social Security # _____________

Referred by: Patient (Name) _______________________________

TV / Radio / Yellow Pages / Lens crafters

Is this office a provider for your vision insurance? Yes / No

If yes, name of vision plan: _____________

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Have you been a patient in this office before? Yes / No Do you use a computer? Yes / No How many hours a day?____

Do you currently wear glasses? (Yes / No) or contacts (Yes / No)? If so, are they for: distance / near / constant

Reason for your visit today:

___General check up __Annual contact lens exam _____ Lost/Broke glasses ____Problem with contact lens___ Try contact lenses

List *any* medication you currently take (including birth control or hormones): ________________________

List *any* medications you are allergic to: ____________ None): ________ If female, are you pregnant or nursing? Yes/No

List *any* EYE injury, surgery, or disease you have had:__________________________________ None _______

**Personal Eye History**

| | Circle yes or no | |
|---|---|---|
| Headaches | Yes | No |
| Glare / Light Sensitivity | Yes | No |
| Burning | Yes | No |
| Dryness | Yes | No |
| Excess Tearing / Watering | Yes | No |
| Eye Pain or Soreness | Yes | No |
| Itching | Yes | No |
| Mucous Discharge | Yes | No |
| Blurred Vision Distance | Yes | No |
| Blurred Vision Near | Yes | No |
| Double Vision | Yes | No |
| Floaters or Spots | Yes | No |
| Loss of Side Vision | Yes | No |

**Blood Relative and Personal History** (Check here if none apply__)

| | Circle | | Whom? |
|---|---|---|---|
| Amblyopic (Lazy Eye) | Self | Relative | ______ |
| Cataract | Self | Relative | ______ |
| Color Blind | Self | Relative | ______ |
| Glaucoma | Self | Relative | ______ |
| Macular Degeneration | Self | Relative | ______ |
| Retinal Problems | Self | Relative | ______ |
| Strabismus (Eye Turn) | Self | Relative | ______ |
| Arthritis | Self | Relative | ______ |
| Cancer | Self | Relative | ______ |
| Diabetes | Self | Relative | ______ |
| Heart Disease | Self | Relative | ______ |
| High Blood Pressure | Self | Relative | ______ |
| Kidney Disease | Self | Relative | ______ |
| Lupus | Self | Relative | ______ |
| Stroke | Self | Relative | ______ |
| Thyroid Disease | Self | Relative | ______ |

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Method of payment: Cash Visa / Mastercard Check

*All patients are responsible for payment at time of service.*

INFORMATION RELEASE CONSENT: I authorize any holder of medical /optical information to release information about me to Spencer Maudlin, O.D. and I authorize Spencer Maudlin, O.D. to release medical /optical information about me to other health care providers, attorneys, or insurance companies.
NOTE TO MEDICARE PATIENTS: Medicare will not pay for refractive services or other services deemed not medically necessary.

Signed ______________________________________________ Date ______/_______/_______
THANK YOU PLEASE RETURN THIS FORM TO THE FRONT DESK

## Consent for Use or Disclosure of Patient Information
## For the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Spencer Maudlin, O.D., and any co-worker or doctor aiding in his "practice", to use or disclose my protected health information for the purpose of providing treatment to me, obtaining payment for vision and health care services rendered to me, or to carry out Dr. Maudlin's Practice (including Mitchell Optical Company) of health care/vision care operations. I also consent to the practice using or disclosing my protected health information for treatment activities provided by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations, including quality assessment and reviewing the competence of health care professionals.

**Specific Records Expressly Excluded.** I DO NOT authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health care information. (Check any you do not agree to authorize to release):

_____ Chemical/Substance _____ Abuse Drugs _____ Alcohol _____ Sexually Transmitted Diseases

I further acknowledge the "practice" has provided me a copy of its notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

______________________________ ______________________________
Signature of Patient or Personal Representative Date

______________________________
Printed Name of Patient or Representative

______________________________
Description of Personal Representative's Authority

I authorize the practice of Spencer Maudlin, O.D. (Including Mitchell Optical Company) to discuss my symptoms, test results/treatment and or account information with the following individuals:

Name Relationship to Patient Phone Number
______________________________________________________________

SPENCER MAUDLIN, OD
Mitchell Optical Company
527 West Main Street
Mitchell, IN 47446

ADVANCED BENEFICIARY NOTICE

DATE__________ PATIENT__________________ COMMERCIAL INS___________

- You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

**WHAT YOU NEED TO KNOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask questions.

| SUPPLIES AND SERVICES | REASON INSURANCE MAY NOT PAY | ESTIMATED COST |
|---|---|---|
| | | |

____YES, I want to receive these services. If my commercial insurance carrier denies payment, I understand that I am completely responsible for payment in full. I understand that I can Appeal this decision for non-payment by my insurance carrier.

____NO, I have decided not to receive these services.

____OTHER, Should I decide to request these services in the future, I understand that, I will be charged and am responsible for payment in full.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

| GUARANTOR or PATIENT SIGNATURE | DATE |
|---|---|
| | |