



Colorado Family Eye Center
Stapleton

EXAM DATE: _____

PATIENT'S FULL NAME (first, middle, last): _____

PATIENT'S NICKNAME: _____ PATIENT'S DATE OF BIRTH: _____

WHAT IS THE REASON FOR THE VISIT TODAY? _____

DID A DOCTOR SEND YOU TO SEE US? NO YES, Dr. _____

IS THE PATIENT ALLERGIC TO ANY MEDICATION? NO YES- If so, please list:

NAME OF MEDICATION	TYPE OF REACTION (i.e.: hives, rash, fever, etc.)

DOES THE PATIENT HAVE ANY NON-MEDICATION ALLERGIES? NO YES- If so, please list:

ALLERGY (i.e.: pollen, animal dander, latex, etc.)	TYPE OF REACTION (i.e.: hives, rash, difficult breathing, etc.)

IS THE PATIENT TAKING ANY NON-OCULAR (not-for-the-eye) MEDICATIONS? NO YES- If so, please list:

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

IS THE PATIENT TAKING ANY OCULAR (for the eye) MEDICATIONS? NO YES- If so, please list:

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

HAS THE PATIENT BEEN DIAGNOSED WITH ANY MEDICAL PROBLEMS? NO YES- If so, please list:

If the patient was premature: Due date: _____ Gestation: _____ Birth weight: _____

HAS THE PATIENT BEEN DIAGNOSED WITH ANY EYE-RELATED PROBLEMS? NO YES- If so, please list:

HAS THE PATIENT HAD ANY NON EYE-RELATED SURGERIES? NO YES- If so, please list:

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT HAD ANY EYE- RELATED SURGERIES? NO YES-If so, please list:

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT BEEN ADMITTED TO THE HOSPITAL IN THE PAST? NO YES- If so, please list:

REASON	DATE ADMITTED	NAME OF HOSPITAL

HAS THE PATIENT HAD ANY TESTING/IMAGING IN THE PAST (i.e.: MRI, EEG, etc.)? NO YES- If so, please list:

TYPE OF TEST	REASON FOR TEST	DATE OF TEST	NAME OF FACILITY	RESULTS

WITHIN THE PAST TWO WEEKS, HAS THE PATIENT HAD ANY HEALTH ISSUES IN THE FOLLOWING AREAS?

- | | |
|---|--|
| <input type="checkbox"/> GENERAL HEALTH _____ | <input type="checkbox"/> GLANDS/HORMONES _____ |
| <input type="checkbox"/> EARS/ NOSE/ THROAT _____ | <input type="checkbox"/> NEUROLOGICAL _____ |
| <input type="checkbox"/> RESPIRATORY/LUNGS _____ | <input type="checkbox"/> BRAIN/ MENTAL _____ |
| <input type="checkbox"/> HEART _____ | <input type="checkbox"/> BONES/JOINTS _____ |
| <input type="checkbox"/> DIGESTIVE _____ | <input type="checkbox"/> BLOOD _____ |
| <input type="checkbox"/> FEMALE/MALE HEALTH _____ | <input type="checkbox"/> ALLERGIES/IMMUNOLOGICAL _____ |
| <input type="checkbox"/> SKIN _____ | <input type="checkbox"/> OTHER _____ |

IS THERE ANY FAMILY HISTORY OF OCULAR PROBLEMS? NO YES-If so, please list:

Please include family member and eye problem _____

THE PATIENT LIVES WITH: MOM DAD SELF SPOUSE FOSTER PARENTS



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**RELEASE OF INFORMATION-SHORT FORM
(Inspect and Copy Request Form)**

TODAY'S DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

DESCRIPTION OF INFORMATION BEING REQUESTED (eg: medical records): _____

PLEASE SEND THE INFORMATION TO (include name and address): _____

ATTENTION TO: _____

REQUESTED BY (NAME): _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY:

_____ REQUEST ACCEPTED. DATE INFORMATION GIVEN/SENT: _____

_____ REQUEST DENIED. REASON: _____

ACCEPTED/DENIED BY: _____ TITLE: _____

SIGNATURE: _____ DATE: _____



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For your visit today: Please carefully review the following form

1. Sign and date at the bottom

Jean DeMoss OD

Amanda Huston OD

Jessie Dinkel OD

Holly Anderson, OD

MEDICAL VS. ROUTINE: How will your visit be BILLED

How your exam will be submitted to your insurance company will depend not only upon what you tell the doctor, but what the doctor finds upon examination. Remember, there are medical insurances plans that DO NOT cover routine eye exams. Be sure to check your policy(s) to determine your coverage prior to your appointment. It is your responsibility to verify that your routine and/or medical insurance plans are accepted and eligibility is verified. For insurance purposes, eye examinations are divided into two categories:

ROUTINE EYE EXAM My routine vision carrier is: VSP EYEMED Spectera NONE

These are routine eye exams for people who have NO eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lenses) or any potential indicators of eye disease. If your doctor finds anything abnormal during your vision exam, further testing of a medical nature may be needed at another visit. In that case, your medical insurance would be billed.

MEDICAL EYE EXAM My medical insurance carrier is: _____ or NONE

This is a medically necessary comprehensive examination for the diagnosis and treatment of diseases and conditions of the eye performed by a physician/surgeon. This exam evaluates the reasons for the symptoms and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, amblyopia, strabismus, and many other potentially sight-threatening diseases.

******IN ADDITION TO THE EXAM FEE, YOU MAY BE CHARGED FOR ONE OR BOTH OF THE FOLLOWING ITEMS:**

REFRACTION: There is a fee of \$35 (\$30 if paid at the time of the visit) for this test.

You will be asked to pay at the time of your visit. **This fee will be charged to you approximately one time per year.** As a courtesy to our patients, we submit this charge to the insurance companies. If your insurance plan should cover this benefit, we will promptly refund you any balance due back to you. This is a routine charge at all Ophthalmologist, Pediatric Ophthalmologist and Optometrist offices.

*** *What is a refraction?***

A refraction is a measurement taken by an eye doctor to determine whether a patient has nearsightedness (myopia), farsightedness (hyperopia), or astigmatism. An instrument called a retinoscope is used to perform this measurement. Based on the results of the refraction, the doctor decides whether or not to prescribe glasses. A refraction can be accurately performed on a patient of any age, with or without his or her input. For the majority of patients, a refraction is a critical component of an eye examination.

I have read the above information and understand I am responsible for any fees associated with the services provided which maybe non-covered benefits.

Signature of Patient/ Parent/ Legal Guardian: _____

Patient Name: _____ Date: _____

Patient Date of Birth: _____