Colorado Center for Eye Alignment

Patient Health History Form

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

EXAM DATE:_____ 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 (ie: hives, rash, fever, ect.)

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

ALLERGY (ie: pollen, animal dander, latex, ect.)	TYPE OF REACTION (ie: hives, rash, difficult breathing, ect.)

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:

_____

_____

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 (ie: MRI, EEG, ect)? ☐ NO ☐ YES- If so, please list:

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

<u>WITHIN THE PAST TWO WEEKS</u>, HAS THE PATIENT HAD ANY HEALTH ISSUES IN THE FOLLOWG AREAS?

GENERAL HEALTH _____ GLANDS/HORMONES _____

EARS/ NOSE/ THROAT _____ NEUROLOGICAL _____

RESPIRATORY/LUNGS _____ BRAIN/ MENTAL _____

HEART _____ BONES/JOINTS _____

DIGESTIVE _____ BLOOD _____

FEMALE/MALE HEALTH _____ ALLERGIES/IMMUNOLOGICAL _____

SKIN _____ OTHER _____

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

Please, include family member and eye problem _____

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For your visit today: Please carefully Review the following form: Sign & Date at Bottom

Robert King MD, Diana DeSantis MD, Christopher Bardorf MD, Anna Steel MD. Adrienne Ruth MD, Justin Arbuckle MD

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.

SENSORIMOTOR EXAM: There is a fee of $121.00 that will be billed to your insurance company (or a self-pay discount will be applied if you are paying in full at the time of your visit)

*What is a sensorimotor exam?

Pediatric Ophthalmologists are expertly trained in the diagnosis, treatment and management of strabismus (eye misalignment). The sensorimotor exam is performed on patients where extensive measurements are deemed necessary, measured and documented. This evaluation of the eye alignment is more than just a cursory look and is performed when the physician deems it is necessary to aid in the treatment of you or your child.

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:_____

Colorado Center *for* Eye Alignment

Robert A King, MD
Diana M DeSantis, MD
Christopher M Bardorf, MD

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Justin H Arbuckle, MD
Dimitra Triantafilou, CO

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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:** _____