



## PATIENT DATA SHEET

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Alt. Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

\*Appointment reminders will be sent via text message. To opt-out, please inform the front desk.

\*May we contact you on your cellular/mobile phone?  YES  NO

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Sex:  M  F Email: \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

If your visit is due to an accident, please provide the date of the accident and summary:

\_\_\_\_\_

If today is your 1<sup>st</sup> visit, how did you hear about OMEG? \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Optometrist: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Last Visit: \_\_\_\_\_

Preferred Pharmacy Name/Address: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Emergency contact(s) we can call in case of an emergency &/or about your visit if necessary:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary insured/responsible party: Name: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to the patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Alt Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

By signing below, I certify all information is accurate to my knowledge.

I have been provided Oklahoma Medical Eye Group's Patient Information Privacy Notice.

\_\_\_\_\_  
Patient Signature (or authorized representative)

\_\_\_\_\_  
Date



**CONSENT FOR ADDITIONAL TESTING WHILE UNDER THE CARE OF  
OKLAHOMA MEDICAL EYE GROUP**

Your doctor may recommend additional testing to further examine and/or diagnose, including, but not limited to: Fundus Photos, Optical Coherence Tomography (OCT), Pachymetry, Tear Lab, LipiView, External Photography, Visual Field, Visual Evoked Potential (VEP), and Manifest Refraction. By signing this consent, you understand the tests may not be covered or considered medically necessary by your insurance carrier(s), even though approved by other insurances.

<u>Test Type:</u>	<u>Cost:</u>
OCT	\$75.00
Pachymetry	\$37.00
Visual Field	\$126.00
Manifest Refraction	\$45.00
Fundus Photos	\$95.00

I understand that my insurance may or may not approve payment of the above mentioned tests. If my insurance **does not** pay for the tests, I am responsible for any remaining balance or full payment.

**I authorize OMEG to perform testing and/or procedures recommended necessary in the diagnosis and treatment of my care. If I am not the patient, I certify that I am signing on behalf of the patient, as a legal, authorized representative of the patient.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Patient

\_\_\_\_\_  
Date



# REVIEW OF SYSTEMS

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Date: \_\_\_\_\_

Please complete this ENTIRE form:

MEDICAL HISTORY:			MEDICAL HISTORY:			EYE HEALTH HISTORY:					
AIDS/HIV	YES	NO	Shingles	YES	NO	Loss of Vision	YES	NO			
Arthritis	YES	NO	Tuberculosis	YES	NO	Floaters or Spots	YES	NO			
Cancer	YES	NO	Prostate Condition	YES	NO	Dry Eye	YES	NO			
Diabetes	YES	NO	<b>Please list any meds prescribed for Prostate Treatment:</b>			Redness	YES	NO			
Heart Condition	YES	NO				Burning or Itching	YES	NO			
High Blood Pressure	YES	NO				Watering/Tearing	YES	NO			
High Cholesterol	YES	NO				Eye Pain	YES	NO			
Kidney Disease	YES	NO				Blurry Vision	YES	NO			
Lung Disease	YES	NO	<b>Please specify any medical history or condition not listed:</b>			Double Vision	YES	NO			
Lupus	YES	NO						Discharge/Matting	YES	NO	
Stroke	YES	NO						Gritty/Sandy Feeling	YES	NO	
Thyroid Condition	YES	NO						Foreign Object in Eye	YES	NO	
Back Pain/Surgery	YES	NO						Sensitivity to Light/Glare	YES	NO	
Bleeding or Blood Clots	YES	NO	<b>FAMILY HISTORY:</b>			Eye Infection	YES	NO			
Communicable Disease	YES	NO						Crossed Eyes	YES	NO	
Defibulator	YES	NO						Droopy Eyelid	YES	NO	
Epilepsy	YES	NO				Cancer	YES	NO	Cataracts	YES	NO
Headaches	YES	NO				Diabetes	YES	NO	Glaucoma	YES	NO
Hepatitis (Type _____)	YES	NO	Glaucoma	YES	NO	Macular Degeneration	YES	NO			
Joint/Bone Condition	YES	NO	Retinal Detachment	YES	NO	Retinal Detachment	YES	NO			
Pacemaker	YES	NO	Macular Degeneration	YES	NO	Eye Injury	YES	NO			
Respiratory/Asthma	YES	NO	Heart Disease	YES	NO	Flashes of Light	YES	NO			
<b>SMOKING: YES / NO / QUIT</b>			<b>NICOTINE or TOBACCO USE: YES / NO / QUIT</b>								
<b>CURRENT PRESCRIPTION MEDICATION (Please include eye drops and eye medication):</b>											
<b>MEDICATION ALLERGIES:</b>											
<b>SURGICAL HISTORY: (Please list all major surgeries, including ALL eye surgeries or procedures)</b>											
How often do you wear glasses? TV / Reading / Driving / Computer    All the Time / None											
How often do you wear contacts? Everyday / Every Night / Sometimes / Reading / None											
Type of contacts worn? Soft / Hard / Hybrid Right Eye / Left Eye / Both Eyes											
<b>Preferred Pharmacy Name and Address:</b>											
<b>Eye Doctor:</b>					<b>Date of last exam:</b>						
<b>Primary Care Physician:</b>					<b>Date of last exam:</b>						



## CONSENT FOR DILATION WHILE UNDER THE CARE OF OKLAHOMA MEDICAL EYE GROUP

Patient Name: \_\_\_\_\_

Dilation of your eyes is extremely important to thoroughly examine the overall health of your eyes. Without dilation, the doctor can only view a small portion of the back of your eye. By temporarily increasing the size of your pupil through dilation, the doctor has a better view of the inside of your eye, which is helpful to detect and evaluate cataracts, floaters, hypertensive, and/or diabetic retinal changes, and other ocular diseases and abnormalities.

Dilation requires multiple drops instilled into your eye(s). Dilation drops take approximately 10-20 minutes to dilate your pupils. Your distance vision may be slightly blurred, sensitive to bright lights, and reading up close will be blurry for 4 hours or longer. Due to light sensitivity, we provide disposable sun shades to make you more comfortable. Driving may be difficult after the examination.

**I have read and understand the above necessities and benefits of a dilated eye exam.**

\_\_\_\_\_  
Patient (or patient's authorized representative)

\_\_\_\_\_  
Date



## Assignment of Medicare Benefits

I request payment of authorized Medicare benefits be made on my behalf to the Oklahoma Medical Eye Group for any service by a physician of the group. I authorize any holder of personal medical information to be released to the Centers for Medicare and Medicaid Services (CMS) and its agents, as well as any information needed to determine payments of these benefits for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

\_\_\_\_\_  
Patient Signature (or authorized representative)

\_\_\_\_\_  
Date

## Medigap or Other Secondary Insurance

I request that the payment of authorized Medigap or other Insurance benefits be made either by me or on my behalf to the Oklahoma Medical Eye Group, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of my personal or medical information to be released to my Medigap insurer, to determine benefits payable for related services.

This assignment shall remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as the original.

I AM RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE, DEDUCTIBLE, OR NON-COVERED SERVICES.

\_\_\_\_\_  
Patient Signature (or authorized representative)

\_\_\_\_\_  
Date



# Cash Payment Policy General Insurance Payment Policy

The goal of the Oklahoma Medical Eye Group is to provide our patients with exceptional care. For us to maintain this high standard of care, we respectfully request all co-pays, coinsurances, or deductibles, which apply, be paid at the time services are rendered.

Your appointment today may be for an initial consultation; however, the doctor may find it medically necessary to perform additional testing. If you have questions regarding cost, etc. for any additional tests, please ask any of our staff as you or your insurance company will be charged for services rendered. If your insurance company does not pay or denies your claim within 60 days, you are responsible for payment. We will be glad to assist you in determining any benefit information or acquiring any other information needed from your insurance company.

**Authorization:**

I hereby authorize Oklahoma Medical Eye Group to release all medical information necessary for processing of insurance claims to all insurers or their agents. I also authorize OMEG to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning my health plan benefits and payments. I direct the insurance company or health plan administrator to release this information to OMEG and allow a Xerographic copy of my signature to be used. I understand that these provisions will remain in full effect until otherwise revoked by me.

State law requires that we advise you that the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired ImmuneDeficiency Syndrome (AIDS).

**I certify that I have read and understand the above information.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions, including any and all payment obligations.

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Representative to Patient