PATIENT DATA SHEET

PRINT 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 1st 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: (_____)_____-_____

Do you have a medical power of attorney that makes medical decisions for you?

❑ Yes* ❑ No

*If you answered yes, they must be present during your exam.

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

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				Redness	YES	NO
Heart Condition	YES	NO	**Please list any meds prescribed**			Burning or Itching	YES	NO
High Blood Pressure	YES	NO	**for Prostate Treatment:**			Watering/Tearing	YES	NO
High Cholesterol	YES	NO				Eye Pain	YES	NO
Kidney Disease	YES	NO				Blurry Vision	YES	NO
Lung Disease	YES	NO				Double Vision	YES	NO
Lupus	YES	NO	**Please specify any medical**			Discharge/Matting	YES	NO
Stroke	YES	NO	**history or condition not listed:**			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				Eye Infection	YES	NO
Communicable Disease	YES	NO				Crossed Eyes	YES	NO
Defibulator	YES	NO	**FAMILY HISTORY:**			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
Respritory/Asthma	YES	NO	Heart Disease	YES	NO	Flashes of Light	YES	NO

SMOKING: YES / NO / QUIT **NICOTINE or TOBACCO USE: YES / NO / QUIT**

CURRENT PRESCRIPTION MEDICATION (Please include eye drops and eye medication):

MEDICATION ALLERGIES:

SURGICAL HISTORY: (Please list all major surgeries, including ALL eye surgeries or procedures)

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**

Preferred Pharmacy Name and Address:

Eye Doctor: **Date of last exam:**

Primary Care Physician: **Date of last exam:**

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 will 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

OMEG
OKLAHOMA MEDICAL EYE GROUP

Assignment of Medicare Benefits

I request payment of authorized Medicare benefits be made on my behalf to 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 out 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 know as Acquired Immune Deficiency 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