



Today's Date \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
 Email Address \_\_\_\_\_

What is the major purpose of this visit?  
 \_\_\_\_\_  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_

**VERY IMPORTANT! NEW PATIENTS ONLY:**

Who may we thank for referring you to our office?  
 Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

- Another Doctor
- Insurance List
- Saw Sign/Building
- L Lifestyle Magazine
- Newspaper
- Web Page: Which Web Site? \_\_\_\_\_
- Other \_\_\_\_\_

*The mission of Clear Vision Eye Care is to form long term relationships with our patients and community by providing them with the most attentive service by both our staff and doctor. We will strive to maximize patient education, helping each patient understand all aspects of their vision & preventative eye health.*

**Insurance Information**

Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

Do you participate in a flex spending account?

- Yes       No

How will you settle your account today?

- Cash       Check       Credit Card

**Lifestyle Questions**

**Do you.....(check box if your answer is yes)**

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? \_\_Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision             | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn      | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections            | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light            | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness                 | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment        | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                   | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses     |  |
| <input type="checkbox"/> Other eye disorders _____ |  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

**Patient Medical History**

Name of Family Physician \_\_\_\_\_  
 Town \_\_\_\_\_  
 Date of Last Physical Check-up \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter)**  
 (List name of medications including eye drops, vitamins, & birth control pills) \_\_\_\_\_  
 \_\_\_\_\_

Allergies to medications?  Yes  No  
 If so, what medications? \_\_\_\_\_

Have you had any surgeries?  Yes  No  
 Do you use cigarettes/tobacco, alcohol, or other substances?  Yes  No

**Have you ever been diagnosed or treated for the following health problems?**

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Eye History**

Date of Last Eye Exam \_\_\_\_\_  
 By Whom? \_\_\_\_\_

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No  
 What kind? \_\_\_\_\_

Solutions used \_\_\_\_\_

Are you satisfied with the vision and comfort of your contact lenses?  Yes  No

Would you prefer clear contact lenses or colored contact lenses?  Clear  Colored

If you wear bifocals, do the lines or head tilting bother you?  Yes  No

**Family Medical/Eye History (Check all that apply)**

Is there a family medical history of any of the following:  
 No  Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____



**CLEAR VISION**  
 E Y E C A R E

## Clear Vision Eyecare Notice of Privacy Practices

1. ***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.*** The notice is provided in two layer provides further details of our privacy policies and procedures.
2. How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.
3. Your rights. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. Our legal Duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies please contact us.
5. Privacy Complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with the decision we made about access to your health information, you may contact us. You may send a written complaint to the U>S Department of Health and Human Services. We can provide you with the appropriate address upon request.

**If you have any questions or complaints, please contact: Clear Vision Eyecare, 570 Fallbrook Blvd, Suite 108, Lincoln, NE 68521. Phone number 402.742.0399**

**Acknowledgment of receipt of Notice of Privacy Practices:** Please sign and print your name and provide the date below to acknowledge that you have received both layers of the Notice of Privacy Practices.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

I give permission for the following people to have access to my Protected Health Information:

Family Members

Names/Relationship \_\_\_\_\_  
\_\_\_\_\_

Others (Friend, Caregiver, etc.)

Names/Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# *Clear Vision Eyecare*

## **NOW YOU HAVE THE OPTION: DILATION IS NO LONGER NECESSARY FOR A THOROUGH EYE EXAM!**

State-of-the-art laser scanning technology now available allows our doctors to capture an image of your retina.

### This Digital Technology is Completely Safe

Retinal problems such as macular degeneration, glaucoma, retinal holes, Retinal detachments and diabetic reinopathy can now be seen without dilation for most patients. As you know, early detection is crucial!

Dr. Bateman recommends **ALL** patients have a digital image annually with the new scanning digital imaging system. The fee is \$34.00 ( this fee is not covered by any insurance except under certain circumstances when deocumenting existing pathology in the course of medical treatment). The fee is due at the time of service. Here is a quick comparison of the two exams:

#### **Dialated Exam**

vs.

#### **OptoMap Exam**

1. Blurred near vision for 4-6 hrs.
2. Sensitivity to light for 4-8 hrs.
3. Only the doctor can see the retina.
4. No permanent record of the retina.

1. No blurred vision
2. No light sensitivity
3. Patient can see their retina.
4. Retinal image becomes part of patients medical history.

Please check which of the following you prefer to have done today:

\_\_\_\_\_ I want to have the scanning laser image of my retina. I understand that the fee of \$34.00 is due today. (dialation may still be necessary in some circumstances)

\_\_\_\_\_ I prefer a dialated exam. Dilation will cause your vision to be blurry and you will be light-sensitive for up to 8 hours.

\_\_\_\_\_ I understand the benefits of dialation or the optomap pertaining to my eye health I perfer to decline both at this time.

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

OptoMap is not recommended for people with seizure disorders.