PINE CREEK VISION CLINIC

NEW PATIENT NEURO PACKET

Legal Name: _____ Date: _____

Nickname: _____Date of Birth: ____/____/____ Sex: _____SSN: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____Primary Phone #: _____Secondary #: _____

**Optomap** ($39) OR **Dilation** (Please circle one)

**Preferred Language:** ☐ English or ☐ Other ☐ Decline to Answer

**Race:** ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Decline to Answer

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Employer or School: _____ Occupation or Grade: _____

**Referred by**: _____#_____

**Release of Information**

I authorize the release of information (including the diagnosis, records, examination rendered to me and claims information) to be released to the following*: _____

*The release information will remain in effect until terminated by me in writing.

**Insurance Information**

**Payment Policy**: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic. Pine Creek Vision Clinic does not bill Secondary Insurance, if the claim does not cross over it is the patient's responsibility to bill insurance.

**Vision Insurance**: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

**Medical Insurance**: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

**Payment Policy**: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a $50 collection fee."

**Signed**: _____ **Date**: _____

"I hereby authorize release of information to my insurance company or to any health care professional or educational professional when necessary for my healthcare or billing." (This allows us to bill your insurance.)

**Signed**: _____ **Date**: _____

## Dr. Thomas A. Wilson O.D. Pine Creek Vision Clinic Colorado Springs, CO

### ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES
**Revised April 19, 2017**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (719) 594-2020.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO will not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

**Signed**: _____ **Date**: _____

**PINE CREEK VISION CLINIC**
**MEDICAL QUESTIONNAIRE**

Name:_____ Date:_____

Reason for Visit:

- ☐ General Eye Exam
- ☐ Contact Lens Fitting/ Evaluation
- ☐ Evaluation after Trauma/Brain Injury/ Concussion/ Stroke/ Neurological Reason
- ☐ Referral From-_____
- ☐ Other_____

Do you wear glasses? Yes No Do you wear Contacts? Yes No Type of Contacts: Soft Other_____

Date of Last Eye Exam:_____ Eye Doctor:_____

Last Medical Exam:_____ Primary Care Physician:_____

**Medical History:**
Current Medications and Dosage- including contraceptives, over the counter, supplements, vitamins:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications? Yes No If yes, _____

List any major injuries/motor vehicle accidents/concussions/ surgeries/ hospitalizations with dates:

_____

_____

Are you pregnant or nursing? Yes No

**Social History**
Do you drive? Yes No Is driving difficult? Yes No
Do you use any tobacco products (circle one)? > 1 year 1-5 years <5-10 years Occasional Never
Do you consume alcohol (circle one)? Occasional Frequent Never
Do you use any recreational drugs (circle one)? Occasional Frequent Never
Have you ever been exposed to or infected with: AIDS/HIV Gonorrhea Hepatitis Syphilis
Hobbies/Sports:_____
Occupation:_____

- ☐ I would prefer not to discuss my social history

**Review of Systems**

Do you currently, or have you ever had problems in the following areas?

**Constitutional**
Yes No Fever, weight gain/loss

**Ear/Nose/Throat**
Yes No Sinus Congestion
Yes No Dry mouth/throat

**Cardiovascular**
Yes No Heart Pain
Yes No High blood pressure
Yes No Vascular Disease
Yes No Heart Surgery

**Respiratory**
Yes No Asthma
Yes No Chronic Bronchitis
Yes No Emphysema

**Genitourinary**
Yes No Dialysis/kidney failure

**Gastrointestinal**
Yes No Diarrhea
Yes No Constipation

**Musculoskeletal**
Yes No Rheumatoid arthritis
Yes No Muscle Pain
Yes No Joint Pain

**Integumentary (Skin)**
Yes No Eczema
Yes No Skin cancer

**Neurological**
Yes No Headaches
Yes No Migraines
Yes No Concussion
Yes No Stroke

**Psychiatric**
Yes No Depression
Yes No Anxiety

**Endocrine**
Yes No Diabetes
Yes No Hyper/Hypo thyroid

**Hematologic/ Lymphatic**
Yes No Anemia
Yes No Bleeding problems

**Allergic/ Immunologic**
Yes No Lupus
Yes No Hay fever/ allergies

**Please explain if you have answered yes to any of the conditions above or have any conditions not listed:**

_____

_____

**Ocular History**

Yes No Glaucoma
Yes No Cataracts
Yes No Diabetic Retinopathy
Yes No Retinal Disease
Yes No Eye Injury
Yes No Blindness
Yes No Cross/turned eye
Yes No Lazy eye/ amblyopia
Yes No Keratoconus

Yes No Decreased vision
Yes No Dry eye
Yes No Burning eyes
Yes No Itching eyes
Yes No Double vision
Yes No Eye pain
Yes No Floaters
Yes No Flashes of light
Yes No LASIK/ Other eye surgeries

**Please explain if you have answered yes to any of the conditions above or have any conditions not listed:**

_____

_____

| **Family History** | | | **Relationship** |
|---|---|---|---|
| Blindness | Yes | No | _____ |
| Cataract | Yes | No | _____ |
| Glaucoma | Yes | No | _____ |
| Macular Degeneration | Yes | No | _____ |
| Retinal Degeneration | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Heart Disease | Yes | No | _____ |
| High Blood Pressure | | | |

☐ **UNKNOWN FAMILY HISTORY**

**PINE CREEK VISION CLINIC**
**INJURY INFORMATION**

Patient Name: _____ Date:_____

Date of Accident: _____ State: _____

Please briefly describe the injuries or accident that have led to your current vision problems:_____

_____

_____

_____

_____

Did you lose consciousness? Yes No

If so, for how long?_____

Please circle if this was a:

Motor Vehicle Accident Sports Concussion Other_____

If this was a motor accident:

Were you a: Driver Passenger Pedestrian

Were you on a: Highway Street Parking Lot

If you were on a highway:

Were you: Entering Exiting On the Highway

Were you: Moving Stopped

When did you begin to notice difficulties with your vision?_____

Please list all previous injuries, concussions, surgeries, or motor vehicle accidents including the year of the occurrence:_____

_____

_____

_____

Has a vision/eye exam been performed since the injury? Yes No

If yes, by whom?_____ Date:_____

Doctor Recommendations?_____

# Insurance Info

Exam Date:_____

Patient Name:_____ DOB:_____

Date of Loss/Accident: _____ State:_____ What?_____

Attorney

Company:_____ Name:_____

Phone #:_____ Fax #: _____

Referred By

Name:_____ Phone:_____

Payor Source

Medical Insurance

Name:_____ Policy #:_____ Group #:_____

Vision Insurance (for glasses only)

Name:_____ Policy #:_____ Group #:_____

Auto/Workers Comp

Company:_____ Case #:_____

Case Manager: _____Phone #:_____

Email:_____ Fax #:_____

Mailing Address: _____

Billing Address: _____

Notes: _____

_____

_____

_____

**Your name**: _____ **your age** ____ **today's date**: _____

☐ I have had a medical diagnosis of brain injury (check box if true). My brain injury was: ___ years ago

☐ I suffered a brain injury without medical diagnosis (check box if true)

☐ I have NOT had a previous brain injury (check box if true)

***Please check the most appropriate box, or circle the item number that best matches.***

***Circle a number below:***

| **Please rate each behavior.** **How often does each behavior occur?** (circle a number) | **Never** | **Seldom** | **Occasionally** | **Frequently** | **Always** |
|---|---|---|---|---|---|
| Clarity of vision changes or fluctuates during the day | 0 | 1 | 2 | 3 | 4 |
| Eye discomfort / sore eyes / eyestrain | 0 | 1 | 2 | 3 | 4 |
| Headaches or dizziness after using eyes | 0 | 1 | 2 | 3 | 4 |
| Eye fatigue / very tired after using eyes all day | 0 | 1 | 2 | 3 | 4 |
| Feel "pulling" around the eyes | 0 | 1 | 2 | 3 | 4 |
| Print moves in and out of focus when reading | 0 | 1 | 2 | 3 | 4 |
| Normal indoor lighting is uncomfortable – too much glare | 0 | 1 | 2 | 3 | 4 |
| Indoors fluorescent lighting is bothersome or annoying | 0 | 1 | 2 | 3 | 4 |
| Clumsiness / misjudge where objects really are | 0 | 1 | 2 | 3 | 4 |
| Lack of confidence walking / missing steps / stumbling | 0 | 1 | 2 | 3 | 4 |
| Side vision distorted / objects move or change position | 0 | 1 | 2 | 3 | 4 |
| What looks straight ahead--isn't always straight ahead | 0 | 1 | 2 | 3 | 4 |
| Avoid crowds / can't tolerate "visually-busy" places | 0 | 1 | 2 | 3 | 4 |
| Short attention span / easily distracted when reading | 0 | 1 | 2 | 3 | 4 |
| Difficulty / slowness with reading and writing | 0 | 1 | 2 | 3 | 4 |
| Poor reading comprehension / can't remember what was read | 0 | 1 | 2 | 3 | 4 |
| Confusion of words / skip words during reading | 0 | 1 | 2 | 3 | 4 |
| Lose place / have to use finger not to lose place when reading | 0 | 1 | 2 | 3 | 4 |



Predictive score = ≥ 28

**total score for all 18-items: _____**