



NEW PATIENT

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:**

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### 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:**

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### Family History

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 Yes No

### Relationship

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**UNKNOWN FAMILY HISTORY**