Pearl Street Eye

Thank you for choosing our office for your eye care. Please complete the following information.

Patient Name:_____ _____/_____/_____ Gender: M F
Last First MI Date of Birth

Address:_____ _____ _____ _____
Street or PO Box City State Zip

Home #:_____ Cell #:_____ Work #:_____

SS#(last 4): XXX-XX-_____ Email: _____

Employer: _____ Occupation:_____

Person Responsible for Account:_____ Relationship to patient:_____

INSURANCE:

It is your responsibility to be familiar with your insurance policy and its coverage. Your insurance is a contract between you and your insurance company. We will be glad to submit charges to your insurance company one time as courtesy to you. Any co-payments listed on the insurance card are due at the time of service.

REFRACTION FEE:

The Refraction (measuring the prescription power your eyes need) is an important component of your eye exam that most insurance companies require the patient to pay. This fee is covered by major vision insurances such as: VSP, SVP, VCP, VBA, Optum, Blue View Vision & Eye Med. The refraction fee is due at the time of the eye exam.

ANNUAL CONTACT LENS EVALUATION:

Per Colorado state regulations, your contact lens prescription will be valid for up to 1 year. This means you may purchase enough lenses to last 12 months. After 12 months your contact lens prescription expires and a comprehensive exam & contact lens evaluation is needed in order to renew your prescription.

FINANCIAL RELEASE:

I understand if the insurance information I give you is incorrect, or I am found ineligible for coverage for services provided, that I will be responsible for and pay all charges incurred. Full payment is required at the time of service when there is no insurance, unless other arrangements have been made.

_____ _____/_____/_____
INITIALS DATE

INSURANCE INFORMATION:

Please list **BOTH** medical and vision insurance. Your medical insurance will need to be billed if medical diagnoses and/or procedures occur. Your vision insurance will be billed for routine eye exams.

MEDICAL INSURANCE INFORMATION:

Insurance Company:_____ Policy Holder's Name:_____

Billing Address:_____ Phone:_____ DOB:_____/_____/_____

ID#:_____ Group#:_____ Relationship to Policy Holder:_____

VISION INSURANCE INFORMATION:

Insurance Company:_____ Policy Holder's Name:_____

Billing Address:_____ Phone:_____ DOB:_____/_____/_____

ID#:_____ Group#:_____ Relationship to Policy Holder:_____

Signature:_____ Date:_____

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 2014

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Warren Tripp, M.D., P.C.
Pearl Street Eye
2575 Pearl Street #1C
Boulder, CO 80302

Patient Medical History Questionnaire

Patient Name: _____ **Date of Birth:** _____

Current Medications: _____

_____

Drug Allergies: Y / N Please List: _____ What Happens: _____

Seasonal Allergies: Y / N , Explain: _____

Diabetes: Y / N Type?: _____ Date of Diagnosis?: _____ Blood Sugar HgB A1C: _____

Do you have any problems with any of these systems:

Eyes	Y / N	Endocrine (Gland)	Y / N	Nervous/Mental	Y / N
Ears/Nose/Throat	Y / N	Cardiovascular	Y / N	Respiratory	Y / N
Genitourinary	Y / N	Musculoskeletal	Y / N	Skin Problems	Y / N
Gastrointestinal	Y / N	Blood/Lymph	Y / N	Allergic/Immunologic	Y/ N

Please Explain: _____

Current Health Problems: _____

_____

Have you had any Operations: Y / N, Explain: _____

Have you ever had a Blood Transfusion: Y / N HIV: Y / N STD's: Y/ N

What birth order are you: First / Second / Third / Fourth / Fifth / Other: _____

Social History

Do you drink alcohol: Y / N How many per Day/ Week/ Month: _____

Do you use Cigarettes/Tobacco: Y / N How many packs per Day/ Week/ Month: _____

Family History

High Blood Pressure	Y / N Relation _____	Macular Degeneration	Y / N	Relation	_____
Diabetes	Y / N Relation _____	Retinal Detachment	Y / N	Relation	_____
Glaucoma	Y / N Relation _____	Cataracts	Y/ N	Relation	_____
Other Eye Conditions:	Y / N What Kind: _____			Relation	_____

Personal Eye Information

Do you wear glasses: Y / N Contact Lenses: Y / N Lens Type: _____

Do you had/have any of the following:

Glaucoma: Y / N Cataracts: Y / N Dry Eyes: Y / N Blurred Vision: Y / N

Other Eye Problems: Y / N Please Explain: _____

Eye Injuries: Y / N What Kind: _____ Date(s) _____

Eye Operations: _____ Date(s) _____

Additional Information: _____

Whom may we thank for referring you: _____

X _____ X _____

X _____ X _____

For office use only:
Total Speed Score (Frequency + Severity) =_____

SPEED II Questionnaire

Name: _____, _____ **Date:** ____/____/_____
(Last) (First)

Date of Birth: _____/_____/_____ **Sex:** M F (Circle)

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system below:

0 = Never, 1 = Sometimes, 2 = Often, 3 = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the ratings list below:

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark with an X if you have experienced symptoms:

1) Today _____ 2) Within the last past 72 hours _____ 3) Within past 3 months_____

Do you use eye drops and/or ointment? YES NO (Circle) Today? Y N
If yes, which drops do you use?_____ How long are they effective?_____ ____ Last 4 hours? Y N Any Gels Last 12 Hours? Y N Moisturizers, Lotion & Facial Creams Today? Y N Have you touched/rubbed your eye(s) today?? If so when & show us how you rub them. How long ago did you touch/rub them? Any make up today? Y N*

Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis YES NO (Circle) Stye YES NO (Circle)

Do you have fluctuating vision problems? (That can be corrected with blinking)
Circle: Never Sometimes Frequently A Lot/Always