



**THE OFFICE OF
BRETT W. HAMILTON, O.D.
CONFIDENTIAL PATIENT INFORMATION**

Date: _____/_____/_____

PLEASE PRINT

Dr. Mr. Mrs. Ms. Miss _____ Male Female

Address _____ City/State: _____ Zip: _____

Home Phone: _____ Cell/Pager: _____ Work: _____

Age: _____ Date of Birth: ____/____/____ SS #: _____ - _____ - _____ Email: _____

Employer: _____ Occupation: _____

In Case of Emergency, Contact: _____ Phone: _____

Primary Care Physician: _____ City _____

Phone #: _____ Date of Last Visit: _____

Referred by: Phone Book Insurance School Drive By Advertisement Website Other _____
 Doctor _____ Patient _____

If patient is a child or adolescent, please complete the following:

Legal Guardian's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

MEDICAL HISTORY

List any allergies to medicines or other substances: _____

List any medication you are taking (prescription or otherwise): _____

List any reasons for recent hospitalization or surgery: _____

Review of Systems: Do you currently or have you ever had any problems in the following areas:

	Yes	No		Yes	No		Yes	No
Eyes			Endocrine			Neurological		
Loss of vision	___	___	Thyroid	___	___	Headaches	___	___
Blurred vision	___	___	Bones/Joints/Muscles			Migraines	___	___
Double vision	___	___	Rheumatoid arthritis	___	___	Seizures	___	___
Eye injury	___	___	Joint pain	___	___	Respiratory		
Eye surgery	___	___	Hematological			Asthma	___	___
Floaters	___	___	Anemia	___	___	Chronic bronchitis	___	___
Flashes of light	___	___	Vascular/Heart			Emphysema	___	___
Glare/Halos	___	___	Diabetes	___	___	Skin	___	___
Cataracts	___	___	High blood pressure	___	___	Psychiatric	___	___
Glaucoma	___	___	Heart pain	___	___	Gastrointestinal		
Eye pain or soreness	___	___	High cholesterol	___	___	Diarrhea	___	___
Retinal disease	___	___	Ear/Nose/Throat/Mouth			Genitourinary		
Crossed/lazy eye	___	___	Allergies/Hay fever	___	___	Kidney/Bladder/Genital	___	___

Social History

Do you use tobacco? ___ Do you use illegal drugs? ___ Do you drink alcohol? ___

Have you been exposed to or infected with (circle): Gonorrhea Hepatitis HIV Syphilis

Family History

Please note any family history (parents, grandparents, siblings, and/or children—living or deceased) for the following conditions:

Blindness	___	___	Cancer	___	___	High blood pressure	___	___
Retinal detachment	___	___	Heart disease	___	___	Macular degeneration	___	___
Glaucoma	___	___				Diabetes	___	___

Reviewed by: _____ (Doctor's Signature) _____ (Date)

Primary Medical Insurance: _____ **Phone #:** _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's date of birth: _____ Employer: _____ PCP Referral Required: Yes No
Policy #: _____ Group #: _____ PCP: _____

Secondary Medical Insurance: _____ **Phone #:** _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder Date of Birth: _____ Employer: _____ PCP Referral Required: Yes No
Policy #: _____ Group #: _____ PCP: _____

Vision Plan: _____ **Phone #:** _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's date of birth: _____ Employer: _____
Policy #: _____ Group #: _____

DILATION AND OPTOMAP

It is extremely important that Dr. Hamilton obtain a full view of the inside of your eyes. This allows for a more thorough examination and an increased ability to rule out/monitor diseases affecting the eyes such as cataracts, glaucoma, macular degeneration, malignant melanoma, retinal holes, tears and detachments., as well as changes due to diabetes, high blood pressure, and increased cholesterol. This view may be obtained through dilation which is included with any full priced examination or Optomap which is an additional fee of \$34. Dilation uses drops to obtain this view leaving your eyes light sensitive for 4-5 hours. The Optomap obtains the same view using a photograph. Optomap does not require any drops, has no side effects, and allows us to store a photograph for future reference. Both tests are useful and important. In most cases we recommend Optomap. Dr. Hamilton and his staff will discuss which test is best for you.

I have read this statement _____ (initials)

VISUAL FIELD SCREENING

Another important, but optional test is the Visual Field Test. Visual Field testing is performed in order that the doctor may assess the function of the central and peripheral (side) vision. With this computerized test, the quality of the entire visual field is assessed very accurately. Visual field testing helps the doctor evaluate glaucoma, diabetes, macular degeneration, brain tumors, as well as many other diseases. There is an additional charge of \$17.00 for a visual field screening (many insurance carriers do not cover this test).

Yes, I would like to have this test _____ (initials)

No, I would not like to have this test _____ (initials)

INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information. I have the right to refuse I have been offered and/or read the Notice of Privacy Practices for Brett W. Hamilton, O.D. and agree to continue my care with Brett W. Hamilton, O.D. under said terms. I hereby authorize Brett W. Hamilton, O.D. to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

Patient or Legal Guardian's Signature

Date

FINANCIAL & INSURANCE FILING POLICY

All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or co pay. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, or does not pay within 45 days, we will require you to pay the balance. Payment for co pay, deductible, and non covered service is due at the time services are rendered. We accept cash, money order, Visa, MasterCard, Discover, American Express, and Care Credit.

Patient or Legal Guardian's Signature

Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Brett W. Hamilton, O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Brett W. Hamilton, O.D. for any services furnished to me by Brett W. Hamilton, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, co pay, & non-covered services. Co pay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

Patient or Legal Guardian's Signature

Date