



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

How many hours a day do you read or spend on a computer? ___

Please check any symptoms you experience from near work:

Eye fatigue ___ Headaches ___ Sleepiness ___ Near blur ___ Distance blur ___
Words moving on the page ___ Loss of place while reading ___ Need to keep your place with finger ___

MEDICAL HISTORY

List any allergies to medicines or other substances: ___

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

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

Table with 7 columns: System Name, Yes, No, System Name, Yes, No, System Name, Yes, No. Rows include Eyes, Endocrine, Neurological, Bones/Joints/Muscles, Hematological, Vascular/Heart, Respiratory, Skin, Psychiatric, Gastrointestinal, Ear/Nose/Throat/Mouth, Genitourinary.

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 ___ Cataracts ___ 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 #: _____

OPTOMAP AND DILATION

Our practice recommends an Optomap retinal examination. With this test Dr. Hamilton will be able to view your entire retina with no side effects such as blurry vision or light sensitivity. Dr. Hamilton will review the photograph with you and explain what he sees inside your eyes and then the photograph becomes a permanent part of your medical records for future reference. The cost of the Optomap examination is \$30.00. All patients who choose not to do an Optomap will be asked to have their eyes dilated.

I have read this statement _____ (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