Welcome to Guntersville Eye Clinic

Dr. M Suzanne Holmes

First name _____ Last name _____MI ___Suffix ___ Gender: Male Female
DOB____/____/____
Address _____ City _____ State_____ Zip _____
Preferred Cell # _____ _____ Text # _____ Work # _____
Employer / School _____ Occupation _____
Social Security _____-____-_____ Email_____
How would you like to be contacted? Text Cell Phone Email // May we leave you a message on voicemail? Yes No

In case of Emergency who may we contact:

Name: _____ Phone # _____ Relationship _____

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Have you experienced or been diagnosed or treated for any of the following?

EYES
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Dry Eye Syndrome
- ☐ Retinal Tear/Detachment
- ☐ Lazy Eye
- ☐ Eye Injury
- ☐ Eye Surgery/ LASIK

CONSTITUTIONAL
- ☐ Developmental Delays
- ☐ Cancer

EAR/NOSE/THROAT
- ☐ Hearing Loss
- ☐ Sinusitis

NEUROLOGICAL
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Migraines
- ☐ Concussion

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Vascular Disease

RESPRITORY
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea

GASTROINTESTINAL
- ☐ Crohn's, Colitis

GENITOURINARY
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease

MUSCULOSKELATAL
- ☐ Osteoarthritis

SKIN
- ☐ Rosacea
- ☐ Eczema/Psoriasis

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disfunction

HEMOTOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ High Cholesterol

ALLERGY/IMMUNOLOGIC
- ☐ Rheumatoid Arthritis
- ☐ Lupus

OTHER: _____

Primary Care Physician _____ Pharmacy _____

Have you experienced any of the following?
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Flashes/ Floaters
- ☐ Light Sensitivity
- ☐ Burning/Sandy Feeling
- ☐ Dry Eye
- ☐ Redness
- ☐ Tired/Strained Eyes
- ☐ Itching
- ☐ Watery Eyes

Are you interested in?
- ☐ Prescription Glasses
- ☐ Contact Lenses
- ☐ Computer Glasses
- ☐ Sunglasses
- ☐ LASIK

Is there a family history of any of the following (Explain Relationship)
- ☐ Cataracts_____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment/Tear _____
- ☐ Lazy Eye _____
- ☐ Other Eye Disease _____
- ☐ Type I Diabetes _____
- ☐ Type II Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Cancer _____
- ☐ Thyroid Disfunction _____
- ☐ Other_____

Do you use any tobacco products? YES. NO. If so, how often? _____ Have you ever smoked? YES NO
Do you drink alcohol? YES NO How Often?
Please list any eye drops you are using (Prescription or OTC) _____
Please list any current medications_____
_____
Any medication allergies Y N Which medications _____

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OPTOS Photos

____ **Yes**, I wish to pay the **$39.00** for the OPTOS testing, in place of Dilation (Non Diabetic ONLY)

____ **No**, I have elected not to have an OPTOS today and wish to be Dilated, included in exam pricing.

I understand the benefits of the annual OPTOS as:

- Fast, easy, and comfortable
- A permanent record to compare and track potential eye diseases
- An in-depth view of nearly the entire retina
- Educational tool for your doctor to discuss your health and wellness

I understand that an ultra-widefield view of the retina is an important part of a comprehensive eye exam and that I am accepting / declining the Doctor's recommendation to obtain a comprehensive view of my retina.

_____ ____/____/_____

Patient's Signature **Date**

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Read and Initial ALL

_____Guntersville Eye Clinic will file medical/ vision insurance as a courtesy to the patient. Benefits are not a guarantee of payment.

_____All copays, deductibles, glasses or contact totals and any taxes are due at the time of visit.

_____If any financial assistance is needed prior arrangements should be made with the office.

_____You will however be responsible for any additional copays or deductible amounts due from insurance upon
filing claim.

_____ANY amount remaining after insurance payment is made, the patient responsibility should be paid in full within 45 days or Guntersville Eye Clinic has the right to turn your account over to a collection agency.

_____ _____

Signature of Patient or Parent/ Legal Gaurdian **Date**

Acknowledgment of Notice of Privacy Practices

Guntersville Eye Clinic
1327 Gunter Ave. Guntersville AL 35976
256-582-3146

The law requires that Guntersville Eye Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Guntersville Eye Clinic's Notice of Privacy Practice prior to any services offered.
___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Guntersville Eye Clinic to release my personal health information to the following individuals:

_____

_____

_____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of text and email.
___ I do not authorize the use of text and email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____
Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, stepparent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____
Representative Signature / Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor

Medical Records Request

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Secure email: _____

Fax: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

___ Copy of complete medical records including results of diagnostic testing
___ Copy of contact lens prescription
___ Copy of spectacle lens prescription
___ Other information_____

Release Authorized to:

Guntersville Eye Clinic
1327 Gunter Ave.
Guntersville, AL, 35976
Phone: 256-582-3146
Fax: 256-582-4851

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

_____
_____
Print Name DOB (unless signing for minor)

_____ Date _____ / _____ / _____
Patient or legally authorized individual signature

_____
_____
Printed name if signed on behalf of the patient Designate parent or guardian DOB of minor (if signing for minor)