Advanced Eye Care!

Patient Information

Patient's Name (please print)_____ Birth Date _____/_____/_____ M or F

Social Security # _____

Parent or Guardian (if under 18 years of age) _____ Email _____

Primary Phone _____ Home/Work/Cell Secondary Phone _____ Home/Work/Cell

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Street Address _____ City_____ State/Zip _____

Employer _____ Occupation _____

Emergency Contact_____ Phone Number _____

Date of Last Eye Exam_____ Name of Last Eye Doctor _____

Date of Last Physical Exam _____ Name of Medical Doctor_____

Height: _____ Current Weight: _____

Whom may we thank for referring you? _____

Medical History

(Circle the appropriate answer):

If you answer yes to the following questions, a technician will ask you for details.

1. Do you have glaucoma? ..... Yes No
2. Do you have cataracts? ..... Yes No
3. Have you ever had eye surgery? ..... Yes No
4. Have you ever had an eye injury? ..... Yes No
5. Have you ever had temporary loss of vision? ..... Yes No
6. Have you ever had a lazy eye? ..... Yes No
7. Do you have double vision? ..... Yes No
8. Have you had recent weight loss/gain? ..... Yes No
9. Do you have diabetes? ..... Yes No
10. Have you ever been diagnosed with high blood pressure? ..... Yes No
11. Do you have heart trouble? ..... Yes No
12. Have you ever been diagnosed with lung problems? ..... Yes No
13. Have you ever had a stroke? ..... Yes No
14. Have you ever had stomach or intestinal problems? ..... Yes No
15. Have you ever had urinary tract problems? ..... Yes No
16. Have you ever been diagnosed with cancer? ..... Yes No
17. Have you ever been diagnosed with thyroid disease? ..... Yes No
18. Do you have bleeding problems? ..... Yes No
19. Do you have arthritis? ..... Yes No
20. Have you ever been hospitalized? ..... Yes No
21. Have you ever used IV drugs? ..... Yes No
22. List any other illnesses or conditions you are being followed for and whom you are being treated by:

_____

_____

List previous surgeries and dates:

_____

_____

List your current medications and dosages:

_____

_____

_____

List all allergies to eye drops or medications:

_____

Family History

Do you have a family history of any of the following:

1. Diabetes? ..... Yes No
2. Retinal Detachment? ..... Yes No
3. Glaucoma? ..... Yes No
4. Macular Degeneration? ..... Yes No
5. Other (please explain): _____

Visual History

1. Do you wear bifocals? ..... Yes No
   If so, are you bothered by head tilting or restricted vision? ..... Yes No
2. Do you use the computer more than 1-2 hours per day? ..... Yes No
3. Are you bothered by reflections, particularly at night? ..... Yes No
4. Are your current eyeglasses uncomfortable? ..... Yes No
5. Are you interested in wearing contact lenses? ..... Yes No

Social History -- *This information is kept strictly confidential.*

If you smoke, how many packs per day? _____

If you have ever smoked, how many packs per day and approximate date you stopped? _____

Do you drink alcohol? Yes No Amount/How long? _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Have you traveled out of the country in the last six months? Where? _____

Patient Signature: _____ Date: _____

THIS SECTION MUST BE ANSWERED AND SIGNED – PLEASE CHECK ONE

OPTOMAP: State-of-the-art technology that replaces eye drops and dilation. In 0.25 sec. a full diagnostic scan of your retina is digitally mapped. The doctors educate and share their findings with you. This test is critical in the Early Detection of eye diseases like Glaucoma, Diabetes, Macular Degeneration, High Blood Pressure, Retinal Tears, Holes, Detachments, Certain Cancers and Tumors. The Optomap is highly useful for routine annual preventative eye health care. At the present time, some insurance plans do not cover Optomap. The fee for Optomap is $35.00.

I consent to: OPTOMAP YES NO X _____

PUPIL DILATION: This test checks for the same serious eye conditions as above. We use eye drops that take about 20-30 minutes to take effect. Side effects are blurred vision up close and light sensitivity. It takes approximately 4-6 hours to recover from dilation. Unlikely side effects from dilation could be a sharp sudden rise in the pressure of your eyes, creating an ocular emergency. If we determine you are a risk for dilation, or you are pregnant or nursing, your pupils will NOT be dilated. You will usually be able to drive home afterwards.

I consent to: DILATION YES NO X _____

Acknowledgement
Of
Notice Of Privacy Practices

The law requires that Maria G. Ceballos-Corral OD & Griselda Benavides OD make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that

- ▫ I have read or had explained to me Maria G. Ceballos-Corral OD & Griselda Benavides OD Notice of Privacy Practice and agree to continue my care with Maria G. Ceballos-Corral OD & Griselda Benavides OD under said terms.
- ▫ I was given the opportunity to read Maria G. Ceballos-Corral OD & Griselda Benavides OD's Notice of Practices and decline but wish to continue my care with Maria G. Ceballos-Corral OD & Griselda Benavides OD under the terms of Maria G. Ceballos-Corral OD & Griselda Benavides OD's privacy policies.
- ▫ I have read or had explained to me Maria G. Ceballos-Corral OD & Griselda Benavides OD and do not wish to continue my care with Maria G. Ceballos-Corral OD & Griselda Benavides OD under said terms.
- ▫ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as.

_____

_____

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

_____ _____

Patient Date

If you are signing as a personal representative of the patient, Please indicate your relationship.

_____ _____

Representative Date

BLANKET ASSIGNMENT

I request that payment of authorized medical benefits be made to Advanced Eye Care for any services provided or materials furnished by them. I authorize any holder of insurance information needed to determine my benefits to release information to Advanced Eye Care related to the services provided to me.

I request and authorize Advanced Eye Care on my behalf to inquire about medical benefits, in regard to its payment(s) for charges incurred by Advanced Eye Care. However, in the event that my insurance is unable to provide payment, I agree as the patient to pay for services rendered.

_____ _____

Patient or Guarantor Signature **Date**

Records Release

Advanced Eye Care of Odessa
4702 E. University
Odessa, Tx.79762
Dr. Maria G. Ceballos
Dr. Griselda Benavides

432-550-4245 OFFICE
432-550-4370 FAX
Name of last eye Doctor

This is a request from the patient listed below to have Dr._____ release any records and all information on:

Name: _____
DOB: _____
Appointment Date & Time: _____

Patient's Name: _____
(Please Print)

_____ _____
Patient's Signature Date