Dunes Eye CONSULTANTS | Dunes LASIK CENTER

Patient Information

305 Dakota Dunes Blvd. • Dakota Dunes, SD 57049 • (605) 232-6900 • duneseye.com

Today's Date

Last Name First Name

Middle Name Nickname

Suffix: (Jr, Sr, II) Cred.: (MD, DO, OD, DDS, DC, PA, NP)

Address

City State/Prov Zip Code

Date of Birth Age Social Security Number

❍ Male ❍ Female Preferred Language

Race: ❍ Patient Declined ❍ Unknown ❍ American Indian ❍ African American
❍ Other ❍ White ❍ Native Hawaiian/Pacific Islander ❍ Asian

Ethnicity: ❍ Patient Declined ❍ Hispanic/Latino ❍ Not Hispanic or Latino

We now offer notices via text message and email.

Home Phone Work Cell

Email

Marital Status: ❍ S ❍ M ❍ D ❍ W

Employed/School Status: ❍ Full Time ❍ Part Time ❍ Not Employed ❍ Retired ❍ Active Military

Employer/School

Occupation

Address

City State/Prov Zip Code

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Medical Questionnaire

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Last Name First Name

Ocular History

When was your last eye exam? Location

Have you been diagnosed or currently suffering with any of the following eye diseases or medical eye conditions?

❍ Dry Eye ❍ Diabetic Retinopathy ❍ Lazy Eye, Ablyopia or Strabismus ❍ Allergy Eye
❍ Retinal Degeneration, holes or tears ❍ Pterygium ❍ Vision-Related Headache ❍ Pink Eye
❍ Pinguecula ❍ Cataract ❍ Eye Injury ❍ Color Blindness ❍ Glaucoma or Glaucoma Suspect
❍ Corneal or Surface Disease ❍ Macular Degeneration ❍ Lid Disease, Stye or Chalazion ❍ Other

Do you currently have any of the following symptoms or concerns?

❍ Floaters ❍ Eye Pain ❍ Watery Eyes ❍ Flashes ❍ Lid Bumps or Skin Tags ❍ Eye Strain
❍ Distorted Vision/Black Out ❍ Droopy/Sagging Eyelid Tissue ❍ Distance Vision Blurred
❍ Glare or Foggy Vision ❍ Discoloration of Eyes ❍ Temporary Vision Loss ❍ Light Sensitive ❍ Other

Do you currently wear contact lenses? ❍ Y ❍ N

Type or brand Solution Brand

Do you currently wear glasses? ❍ Y ❍ N

Past eye surgeries? ❍ Y ❍ N

Type of Surgery Date Eye(s) Affected

Medical Health History

When was your last medical exam? Location

Height Weight Name of Physician

Do you have any of the following systemic health conditions that may affect your eye health?

❍ Hypertension ❍ Brain Tumor ❍ Lung/Respiratory Disease ❍ Cholesterol ❍ Melanoma
❍ Ear/Nose/Throat Disease ❍ Heart Disease ❍ Eczema ❍ Migraine Headaches
❍ Thyroid Disease ❍ Rosacea Autoimmune Disease ❍ MS ❍ Rheumatoid Arthritis ❍ Other

Diabetes Type I or Type II How Long yrs. Do you know your last A1C score?

Daily Blood Sugar

Date of last diabetic medical visit Treating physician for diabetes

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Dunes Eye Consultants now offers a focused care approach in our specialty clinics for the following conditions: Dry Eye Syndrome, Diabetes, Glaucoma, Cataract, Macular Degeneration, Keratoconus, Myopia

Please list all medications you are taking:

Have you ever taken the following medication? ❍ Prednisone ❍ Plaquenil (Hydroxychloroquine) ❍ Cordarone

Name of Medication	Dosage/Milligrams	How Often

Are you allergic to any medications?

Do you have any other type of allergy?

Do you consume tobacco products? ❍ Y ❍ N If yes are you interested in cessation? ❍ Y ❍ N

Do you consume alcohol products? ❍ Y ❍ N

Family Health History: If yes, who has condition:

Diabetes	❍ Y ❍ N	❍ Father	❍ Mother	❍ Sister	❍ Brother	❍ Son	❍ Daughter
Glaucoma	❍ Y ❍ N	❍ Father	❍ Mother	❍ Sister	❍ Brother	❍ Son	❍ Daughter
Hypertension	❍ Y ❍ N	❍ Father	❍ Mother	❍ Sister	❍ Brother	❍ Son	❍ Daughter
Macular Degeneration	❍ Y ❍ N	❍ Father	❍ Mother	❍ Sister	❍ Brother	❍ Son	❍ Daughter
Cataracts	❍ Y ❍ N	❍ Father	❍ Mother	❍ Sister	❍ Brother	❍ Son	❍ Daughter

Other

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Emergency Contact

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Nearest Relative or Spouse Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Phone Number _____

Employer _____ Work Number _____

Relationship to patient _____

Parent - please complete if patient is a minor

Parent's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Cell Phone _____

Employer _____ Work Number _____

Policy Holder (if different from above) _____ Date of Birth _____

Address: _____

City _____ State _____ Zip _____

Social Security Number _____ Cell Phone _____

Employer _____ Work Number _____

How did you hear about us?

- ❍ Billboard
- ❍ TV Commercial
- ❍ Website
- ❍ Yellow Pages
- ❍ Print Ad
- ❍ Patient Referral

Whom can we thank for referring you _____

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Financial Policy and Signature on File

All signatures are valid for one year from the date written on this form.

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During a Well Vision appointment a medical eye condition may be detected and/or specialized testing may be required to help in the diagnosis, treatment or continued management of your eye care. You may need to be rescheduled for further evaluation to one of our specialty clinics for necessary medical testing and assessment if not advisable to be performed on the same day. Some or all of these fees may not be covered by your vision or medical insurance plan. We will aid in the research of all of your benefits and will strive to discuss this with you sshould there be any unexpected out-of-pocket fees. Upon request, a predetermination of benefits can be provided; however, this is not a guarantee of payment from your insurance carrier or Dunes Eye Consultants.

Name of Patient _____

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of my evaluation today and any subsequent office visit(s). I also understand and agree to accept full responsibility for any overages, denials or non payment on all or any of my claims should my insurance deny all or part of my claims. I understand and agree that I am responsible for expenses incurred the day of my examination such as deductible, co-pay, coinsurance or any overages set by my insurance carrier and must be paid upon check out.

Patient/Guarantor Signature _____ Date _____

SIGNATURE ON FILE FOR INSURANCE

I hereby authorize Dunes Eye Consultants to submit my insurance claims and that payment of authorized insurance benefits (including Medicare benefits) for any services rendered to me be made on my behalf to Dunes Eye Consultants. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guarantor Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Dunes Eye Consultants Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. The terms of our Notice of Privacy may change, and if we change our Notice of Privacy, you may obtain a revised copy by contacting our office. Dunes Eye Consultants provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Dunes Eye Consultants has a Notice of Privacy Practices, and the patient has the right and opportunity to review this notice upon request or before signing this consent.
- Dunes Eye Consultants reserves the right to change the Notice of Privacy Practices.
- The patient has the right to request how protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.
- The patient may revoke this consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on the patient's prior consent.
- By signing this form, you consent to our use and disclosure of protected health information about you for your treatment payment, or health care operations.

Patient/Guarantor Signature _____ Date _____

NOTICE OF SCHEDULING POLICY

You, the patient, are responsible for attending scheduled appointments at the times reserved for you. If you are unable to attend your appointment, please notify us as soon as possible, preferably 72 hours in advance. If you are going to be late, please call us to confirm that you can still be seen or if you need to reschedule. If you arrive late, it is possible you may be asked to reschedule. This policy is necessary for the benefit of all patients and will help us to better serve you.

Patient/Guarantor Initials _____