



Thank you for being or becoming a patient of **Corneal Consultants of Colorado and Colorado Eye Consultants**. We value your loyalty and your

Please indicate any changes from the LAST visit.

Name: _____ **Date of Birth:** _____

Today's Date: _____ Primary Care Physician: _____ Ph #: _____

Eye Doctor (outside CCC): _____ Ph #: _____

Doctor who Referred you to CCC: _____ Ph #: _____

What is the reason for your visit today? _____

Past/Current Medical History: Please check if you have any of the following conditions

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes (Age at onset ___ yrs.)	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Irregular heartbeat	Endocrinologist: _____	<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Radiation treatment
<input type="checkbox"/> Cancer of any kind	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Seizures
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke

Past Surgeries: Please list types and dates of all surgeries

_____	_____	_____
_____	_____	_____
_____	_____	_____

Eye History: Please check and note if involving your right eye, left eye, or both eyes

<input type="checkbox"/> Pink eye	<input type="checkbox"/> Dry eye(s)	<input type="checkbox"/> Ocular migraine
<input type="checkbox"/> Inflamed eyelids	<input type="checkbox"/> Glasses	<input type="checkbox"/> Retinal Tear <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Cataract(s) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Glaucoma <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Strabismus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Macular degen <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Floaters <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Corneal dystrophy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Narrow angles <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> Ocular Hypertension <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	_____

Eye Surgery: Please check all that apply

<input type="checkbox"/> Blepharoplasty <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Lasik/PRK <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> YAG Laser capsulotomy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Cataract surgery <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Laser - narrow angles <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Punctal plugs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Corneal transplant <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Laser - open angles <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Retinal laser <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Eye injections <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Ptosis repair <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Other: _____

Family History: Please check all that apply and indicate relationship (i.e. mother, father, sibling)

<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Macular degeneration _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Migraines _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Retinal detachment _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Strabismus _____

Medications: Please list all medication you take regularly - please use additional pages if necessary

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete the reverse side of this form.

Allergies: Please list all allergies

Demographic Information: Required to receive Federal funding		<input type="checkbox"/> I decline to provide
Preferred language:	<input type="checkbox"/> English	<input type="checkbox"/> Other _____
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
Race	<input type="checkbox"/> American Indian or Native Alaskan	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Native Hawaiian or Pacific islander	<input type="checkbox"/> White
	<input type="checkbox"/> Asian	<input type="checkbox"/> Other _____
	Smoking status:	<input type="checkbox"/> Never smoker
	<input type="checkbox"/> Current everyday smoker	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Current some day smoker	<input type="checkbox"/> Light smoker
	<input type="checkbox"/> Former smoker	<input type="checkbox"/> Heavy smoker
	<input type="checkbox"/> Smoker, current status unknown	

Acknowledgement of Notice of Privacy Practices (HIPAA) - Please check to acknowledge agreement		
<input type="checkbox"/> I acknowledge that Corneal Consultants of Colorado/Colorado Eye Consultants <i>Notice of Privacy Practices</i> was made available to me.		
Assignment of Benefits and Choice of Type of Insurance Used - Please check to acknowledge agreement		
<input type="checkbox"/> I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my call cellular and landline devices using automated dialing systems.		
Choice of Insurance - Vision or Medical (Determined at completion of your visit)		
<input type="checkbox"/> Vision Eye Examination - You must have a <u>VISION INSURANCE benefit</u> (i.e., VSP, EyeMed, Davis, or Spectera) to use this type of insurance. A vision eye examination is performed when there is NO underlying medical condition other than simple changes in your vision that can be corrected using glasses or contact lenses. Many vision insurances will pay for fees associated with receiving a		
<input type="checkbox"/> Medical Eye Examination - You must have a <u>MEDICAL INSURANCE benefit</u> that covers your eye care. These examinations are for the diagnosis and treatment of eye diseases. Medicare, Medicaid and many other insurances will NOT reimburse CCC/CEC for the cost of the refraction, so if you are here for a MEDICAL EXAMINATION and you would like to receive a new or revised eyeglass prescription, you will be required to pay \$45 when you check out today. By checking this box, you consent to pay this fee. You will receive a printed copy of your prescription at the time of your check-out today.		
<input type="checkbox"/> I do not want a refraction today		
<input type="checkbox"/> I do not have Vision or Medical Insurance - I agree to pay ALL costs associated with today's visit following my visit today.		
_____	_____	_____
Print Name	Sign Name	Date
_____	_____	_____
Print Name of Parent/Guardian	Sign Name of Parent/Guardian	Date

Please retain and give to your technician once this form is complete.