Corneal Consultants of Colorado, P.C.

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

Please indicate any changes from the LAST visit.

Name: _____ Date of Birth: _____

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

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

What is the reason for your visit today? _____

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

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

- ☐ Pink eye
- ☐ Inflamed eyelids
- ☐ Cataract(s) ☐R ☐L ☐B
- ☐ Contact lenses
- ☐ Corneal dystrophy ☐R ☐L ☐B
- ☐ Diabetic retinopathy
- ☐ Dry eye(s)
- ☐ Glasses
- ☐ Glaucoma ☐R ☐L ☐B
- ☐ Macular degen ☐R ☐L ☐B
- ☐ Narrow angles ☐R ☐L ☐B
- ☐ Ocular Hypertension ☐R ☐L ☐B
- ☐ Ocular migraine
- ☐ Retinal Tear ☐R ☐L ☐B
- ☐ Strabismus ☐R ☐L ☐B
- ☐ Floaters ☐R ☐L ☐B
- ☐ Other _____

Eye Surgery: Please check all that apply

- ☐ Blepharoplasty ☐R ☐L ☐B
- ☐ Cataract surgery ☐R ☐L ☐B
- ☐ Corneal transplant ☐R ☐L ☐B
- ☐ Eye injections ☐R ☐L ☐B
- ☐ Lasik/PRK ☐R ☐L ☐B
- ☐ Laser - narrow angles ☐R ☐L ☐B
- ☐ Laser - open angles ☐R ☐L ☐B
- ☐ Ptosis repair ☐R ☐L ☐B
- ☐ YAG Laser capsulotomy ☐R ☐L ☐B
- ☐ Punctal plugs ☐R ☐L ☐B
- ☐ Retinal laser ☐R ☐L ☐B
- ☐ Other: _____

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

- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Macular degeneration _____
- ☐ Migraines _____
- ☐ Retinal detachment _____
- ☐ Strabismus _____

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

Allergies: Please list all allergies

Please complete the reverse side of this form.

Demographic Information: Required to receive Federal funding ☐ I decline to provide

Preferred language:	☐ English	☐ Other _____
Gender:	☐ Male	☐ Female
Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino
Race	☐ American Indian or Native Alaskan	☐ Black/African American
	☐ Native Hawaiian or Pacific islander	☐ White
	☐ Asian	☐ Other _____
Smoking status:	☐ Current everyday smoker	☐ Never smoker
	☐ Current some day smoker	☐ Unknown
	☐ Former smoker	☐ Light smoker
	☐ Smoker, current status unknown	☐ Heavy smoker

Assignment of Benefits and Choice of Type of Insurance Used - Please check to acknowledge agreement

☐ I hereby assign to Corneal Consultants of Colorado (CCC), Colorado Eye Consultants (CEC) or any other third-party, benefits available for healthcare services provided to me. I understand that CCC/CEC has the right to refuse or accept the assignment of benefits. If these benefits are not assigned to CCC/CEC, I agree to forward to the Practice all health insurance and any 3rd party payments I receive for services rendered to me immediately upon receipt. I understand that I am responsible to pay ALL non-covered services, including those for refractions, co-payments, deductibles, and co-insurances at the time of service. I understand that I am responsible for providing accurate insurance information - failure to do so may result in nonpayment by the insurance carrier and I will be responsible to pay all fees incurred. My signature below acknowledges agreement with this statement.

Choice of Insurance - Vision or Medical - Please all that apply

☐ **Vision Eye Examination** - You must have a VISION INSURNACE benefit 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 refraction (which provides a prescription for glasses or contact lenses). However, you MUST use your Vision Insurance in order to access this benefit).***

☐ **Medical Eye Examination** - You must have a MEDICAL INSURANCE benefit 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 $35 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.***

☐ **I do not want a refraction today**

☐ **I do not have Vision or Medical Insurance** - I agree to pay ALL costs associated with today's visit following my visit today.

Acknowledgement of Notice of Privacy Practices (HIPAA) - Please check to acknowledge agreement

☐ I acknowledge that Corneal Consultants of Colorado/Colorado Eye Consultants *Notice of Privacy Practices* was made available to me.

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.

For office use only - to be completed by staff

Please send LETTER to (name above):

Dictated Ltr	Exam Note	Diabetic Ltr	Plaquenil	
☐	☐	☐	☐	Primary care physician (name/address above)
☐	☐	☐	☐	Optometrist/Ophthalmologist (name/address above
☐	☐	☐	☐	Endocrinologist
☐	☐	☐	☐	Other _____