SAWYER EYE CENTER

COMPLETE ALL PAPERWORK AND BRING WITH A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.
EXPECT TO BE HERE FOR 2 HOURS FOR YOUR INITIAL VISIT.

WE DO NOT PERFORM CONTACT LENS FITTINGS.

PATIENT REGISTRATION

_____ _____ _____
First name Middle name Last Name

Preferred Name:_____ Sex: Male ____ Female ____

Date of Birth: _____ SSN: _____

Address: _____

City: _____State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

Work Phone: _____Patient email: _____

Contact preference: Home ___ Work ___ Mobile ___ Mail ___

Language _____ Race _____ Ethnicity _____
Or patient declines _____ _____ _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed_____

Primary Care Physician _____

Referring Physician _____

How did you hear about us? _____

Do we have your consent to call, email or to text with appointment reminders? (Yes ____ No____)

EMERGENCY Contact: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

GUARDIAN Name: _____

GUARANTOR if other than patient: _____

DOB: _____ Mailing address if different than patient: _____

_____ City _____ State _____Zip _____

Home Phone: _____ Mobile Phone: _____

SAWYER EYE CENTER

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company.

Payment for treatment is ultimately your responsibility.

Financial/insurance Agreements:

I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to me or to my dependents to Sawyer Eye Center. I understand I am responsible at the time of services for paying any required co-pay or deductible. If, after my claim has been filed, my insurance does not cover my services, I understand that I will be billed and am responsible to pay. I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees. In the event I have no insurance coverage, I understand that I am responsible for payment of services rendered to me or my dependents at the time of service.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY. I UNDERSTAND A $30 CHARGE WILL BE ASSESSED ON ALL RETURNED CHECKS.

_____ _____ _____

Patient/Parent/Guardian **Relationship to patient** **Date**

PRIVACY

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient.

I authorize Sawyer Eye Center to release any of my protected health information necessary to process my medical claims and coordinate/manage my healthcare.

I authorize the practice to disclose or provide my protected health information to the following individual(s). This will allow the practice to discuss my protected health information including care, treatment and diagnosis with this (these) individual(s). If I want to limit disclosure to specific items, I can request a Limited Patient Authorization for Disclosure of Protected Health Information form from Sawyer Eye Center.

_____**Relationship** _____**Phone**_____

_____**Relationship** _____**Phone**_____

_____**Relationship** _____**Phone**_____

A copy of my HIPAA Patient Rights and Privacy Notice has been given to me.

I acknowledge that I have read and understand my rights.

_____ _____

Signature (Patient or Parent/Guardian if Minor) **Printed Name**

Date:_____

SAWYER
EYE CENTER

PRESCRIPTION POLICY

Sawyer Eye Center utilizes an Electronic Medical Records (EMR) system in our office. We have the ability to check your prescription eligibility and download your pharmacy history into our system. We can also fax "mail-order" prescriptions, review prescription benefits and drug formulary – all while you are in our office.

By signing below, you are granting Sawyer Eye Center permission to obtain this information on your behalf.

REFRACTION POLICY

What is refraction and refraction fees?

A refraction is the determination of your best corrected vision when we flip various lenses in front of your eyes and ask, "which is better …. 1 or 2?". The results from the refraction may be used to prescribe new glasses. The results from the refraction are also necessary to determine whether any medical or surgical treatment may be needed for you. As an example, a refraction is used to gauge whether a cataract may be worsening, necessitating surgery. A refraction is needed to decide if an eye disease is causing your loss of vision. In other words, a refraction is used to assess the overall health of the eyes.

Why do I have to pay the refraction fee if my glasses prescription did not change?

It is impossible for us to determine whether your prescription has changed unless a refraction is done. Over time, the eye naturally changes shape and /or develops aging characteristics which can affect your glasses prescription, vision and/or some health issues related to the eye.

The refraction is an essential part of the eye examination, but unfortunately, it is NOT a covered service by Medicare and many insurance companies. Our office fee for the refraction is $35 and this fee is collected at the time of service in addition to any co-payments, co-insurance and deductibles. This fee is subject to change from year to year. By signing below, you agree to pay this fee at the time of service.

Signature of patient or Guarantor: _____

PRINT Patient's Name: _____Date: _____

Print legal Guardian's name, if applicable _____

SAWYER
EYE CENTER

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye. The dilating eye drops are necessary to diagnose your condition.

Dilating drops frequently blur vision for several hours, which varies from person to person and may make you much more sensitive to light. Because of this sensitivity, sunglasses should be worn when your eyes are dilated. Disposable sunglasses are available free of charge at our check-out desk.

It is not possible for your ophthalmologist to predict how much your vision will be affected. After an examination, your ability to drive safely may be impaired due to the effect of the dilating drops on your vision. Therefore, it is up to you to determine your ability to drive. You may need to make arrangements to be driven to and from your appointments.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and completely understand the above information regarding dilating eye drops. I have been advised that because my vision may be impaired, I may need to make arrangements to have someone drive me. If I choose to drive or operate machinery despite this warning, I assume full responsibility (financial and otherwise) for the consequences resulting from this choice.

I agree that my doctor, Sawyer Eye Center, LLC, and its employees are released from all liability resulting from my driving or operating machinery while my eyes are dilated.

I hereby authorize my doctor, and/or such assistants as may be designated by him/her, to administer dilating eye drops.

I understand that the use of dilating drops may be necessary to diagnose and evaluate my condition. I hereby consent to the use of dilating drops at my initial visit, and when necessary, at any future visits.

PRINTED PATIENT NAME_____DATE_____

PATIENT SIGNATURE _____

SAWYER EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Preferred Name _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy: _____

Location (street, city, zip)_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American Sex: □ Female □ Male

□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Height: _____ Weight: _____

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

Do you wear Contact Lens ( ) Yes ( ) No Mono Vision Contact Lens ( )Yes ( ) No

□ Cataracts	□ Hyperopia (Far sighted)	□ Myopia (Near sighted)	□ Amblyopia (Lazy eye)
□ Diabetic Retinopathy	□ Iritis	□ Optic Neuritis	□ Aphakia
□ Dry Eyes	□ Keratoconus	□ Retinal Detachment	□ Astigmatism
□ Glaucoma	□ Macular Degeneration		

Other_____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**	**R - L**
□ □ Foreign Body Removal	□ □ Punctal Plugs	□ □ Laser	□ □ Cataract Surgery
□ □ Blepharoplasty	□ □ Retinal Laser Surgery	□ □ RK	□ □ LASIK
□ □ PRK	□ □ Vitrectomy	□ □ Corneal Transplant	
□ □ Strabismus (eye muscle) Surgery			

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Other Medical History: □ No history of illnesses

□ Anemia	□ COPD	□ High Blood Pressure	
□ Arthritis(rheumatoid or osteo)	□ Diabetes Type 1	□ High Cholesterol	□ Migraine
□ Arrhythmia	□ Diabetes Type 2	□ HIV/ AIDS	□ Polymyalgia
□ Asthma	□ Eczema	□ Kidney Disease	□ Psychiatric Disorder
□ Auto Immune disorders	□ Fibromyalgia	□ Kidney Stones	□ Skin Cancer
□ Bleeding Disorder	□ Hepatitis A / B / C	□ Liver Disease	□ Stroke
□ Cancer	□ Hearing Loss	□ Lung Disease	□ Syphillis
□ Chicken Pox	□ Herpes Zoster / Shingles	□ Meningitis	□ Toxoplasmosis
□ Congestive Heart Failure	□ Histoplasmosis	□ MRSA	□ Wound Infection
□ Herpes Simplex	□ Headache	□ Lupus	□ Thyroid Disease

Other_____

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: (Please indicate only ONE immediate family member)

□ Arthritis _____	□ Diabetes_____	□ Kidney Disease_____
□ Blindness_____	□ Glaucoma_____	□ Lazy eye_____
□ Cancer _____	□ Heart Disease_____	□ Macular degeneration_____
□ Cataracts_____	□ High Blood Pressure_____	□ Retinal Disease_____
□ TB_____	□ Stroke_____	

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often? _____

Drug Use: □ Yes □ No If yes what and how often? _____