Omaha Primary EyeCare

Patient Name _____ Preferred Name _____

Street Address City State Zip Code

_____

_____Primary Cell/Work/Home

_____Secondary Cell/Work/Home

_____Email Address

_____ _____

Date of birth Social Security Number

Primary Care Physician/Endocrinologist or NONE:_____

Preferred Pharmacy: _____

Employer and Occupation OR School and Grade: _____

Person responsible for account, if someone other than yourself: _____

Hobbies/Interests: _____

We are required by insurance companies to ask for the following information. We would appreciate your answers so we can avoid payment penalties from insurers.

Preferred Language: _____

Race: American Indian or Alaska Native Asian Black or African American Caucasian
Native Hawaiian or Other Pacific Islander Hispanic or Latino Other Race Refuse to Specify

Height: _____ ft. _____ in. Weight: _____ lbs.

Do you have any allergies to medications?
Please list:

Do you have any general allergies?
Please list:

Are you currently taking any medications?
Please list or bring a copy with you:

We ask that the patient's portion of the billing be paid at the time services are rendered. Payment from your insurance company is to be paid directly to Omaha Primary Eye Care. I understand that the insurance benefits I receive are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. The undersigned accepts full responsibility for any bill incurred at this office that is not covered or paid for by their insurance company. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. I am aware that my glasses and finalized contact lens prescriptions will be available on my patient portal. Furthermore, I consent to receive my prescription through that portal. My signature below acknowledges that I have read and understand the previous statements and that I have had the opportunity to receive/review OPEC's Privacy Policy Notice.

_____ _____

Signature of patient or guardian Date

Omaha Primary EyeCare

What brings you to our office today?

Have you ever been diagnosed with any of the following conditions? (Please circle)

Cataracts Age-Related Macular Degeneration Glaucoma Diabetes

Dry Eye Diabetic Retinopathy Eye Infection, Inflammation or Allergy

Floaters and/or Flashes of light Iritis or Uveitis Retina defects or Degenerations

Are you having any of the following eye concerns? (Please circle)

Redness Burning Itching Tearing Discharge

Are you having any of the following vision concerns? (Please circle)

Blurred vision Eyestrain Severe sensitivity to lights

Headache Poor night vision Bothersome night glare

Double vision Total loss of vision Eye Pain

Do you have medical conditions pertaining to the following body systems? (Please circle)

Ear/Nose/Throat Neurological Psychiatric

Cardiovascular Respiratory Gastrointestinal

Kidney/Bladder Musculoskeletal Skin

Thyroid Diabetes Allergy/Immune

Do you drink alcohol? (Please circle)

No Occasional 1 per day 2-3 per day 4+ per day

Do you smoke? (Please circle)

Never a smoker Former smoker Yes, daily Yes, occasionally

Have any of your immediate family members had any of the following conditions? (Please circle)

Cancer Diabetes Hypertension Thyroid disorders

Cataracts Macular Degeneration Glaucoma Retinal Detachment

Omaha Primary EyeCare

OMAHA PRIMARY EYE CARE, P.C.

Drs. Kubica, Langford and Johnson

1011 S 180th Street

Elkhorn, NE 68022

402-330-3000

AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

I, _____, authorize

(Patient's Name/Guardian)

_____

(Primary Care Physician's First & Last Name)

to disclose the following information for,_____,

(Patient's Name)

date of birth_____:

eTOC (Medication List) : ✓

If you have Direct Email capabilitie according to the MIPS guidelines, such information is to be direct emailed to **communications@direct.revolutionehr.com**
or faxed to Omaha Primary Eye Care PC at 402-330-2166 or mailed to: Omaha Primary Eye Care, PC 1011 S 180th Street Elkhorn NE 68022

This authorization will terminate thirty days from the date noted below.

I understand that if this information is disclosed to a third party, the information may be re-disclosed by the person or entity that received the information and may no longer be protected by federal privacy regulations.

_____ _____

(Signature of patient or representative) (Date)

_____

(Relationship to patient/Authority to sign for patient)