Matthew T. Stanley, O.D.
Darcy D. Stanley, O.D.
Doctors of Optometry

Patient #: ________

PRE-EXAM QUESTIONNAIRE

Name:____________________________________ Sex: M____ F____ Today's Date: ____/____/____

Preferred Name:__________________ Primary Phone:_____________ Secondary Phone:_____________

City:________________ State:____ Zip Code:__________**Email Address:**_________________________

Billing Address (if different than above):____

Birth Date:____/____/____ Age:____ Social Security #:____-____-____ Marital Status:___________

Medical Doctor:_________________ Height:___________ Weight:_____________

Race: □ White □ Black or African American □ American Indian or Alaska Native

□ Asian □ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander

Occupation:_____________ Employer:______________ Work #:___________ Full Time: □ Part Time: □

Student: Full Time: □ Part Time:□ School:____________________ Major:__________________

Are you pregnant and/or nursing? □No □Yes If yes, how far along?______________________

Do you wear glasses? □No □Yes If yes, how old is your present pair of lenses?_________________

Do you wear contacts? □No □Yes If yes, how old is your present pair of lenses?_________________

Type of contacts: □Hard □Soft □Extended Wear (Sleep in them) Are they comfortable? □No □Yes

How often do you replace your contacts?____________ Do you sleep in your contacts? □No □Yes

Are you interested in: Contacts (if not wearing already) □No □Yes Lasik Eye Surgery □No □Yes

Financial/Insurance Information:

Person Responsible for account:_____________ Medical Ins.:_______________ Vision Ins.:_____________

If Insurance is under the name of another person, please provide the following information.

Primary's Name:___________________________ Relationship to patient:____________________________

Date of Birth:___/___/___ Place of Employment:_________________ Social Security #:____-____-____

Address (if different than above):____

Please turn this form over and complete side two

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MEDICAL HISTORY QUESTIONNAIRE

Do you have any allergies to medications? □No □Yes List:____

____

List any medications you take (include oral contraceptives, over the counter medications, and vitamins):

____

____

List any surgeries and /or hospitalizations you have had:____

____

Disease/Condition	No	Yes	Other	Disease/Condition	No	Yes	Other
Allergy/Immunologic				**Ear/Nose/Mouth/Throat**			
Hives	□	□	□	Decreased Hearing	□	□	□
Eczema	□	□	□	Discharge	□	□	□
Rash	□	□	□	Dryness	□	□	□
Lumps	□	□	□	Hoarseness	□	□	□
Cardiovascular				**Hematologic/Lymphatic**			
Chest Pain	□	□	□	Bruising	□	□	□
Palpitations	□	□	□	Bleeding	□	□	□
Difficulty Breathing	□	□	□	Anemia	□	□	□
Endema	□	□	□	**Intergumentary**			
Constitutional				Moles	□	□	□
Fever	□	□	□	Non-Healing Lesions	□	□	□
Chills	□	□	□	Dryness	□	□	□
Weight Gain	□	□	□	Color Changes	□	□	□
Endocrine				**Musculoskeletal**			
Heat/Cold Intolerance	□	□	□	Muscles/Joint Pain	□	□	□
Frequent Urination	□	□	□	Stiffness	□	□	□
Thirst	□	□	□	Back Pain	□	□	□
Appetite	□	□	□	Joint Swelling	□	□	□
Gastrointestinal				**Neurological**			
Heartburn	□	□	□	Dizziness	□	□	□
Nausea	□	□	□	Fainting	□	□	□
Constipation	□	□	□	Seizures	□	□	□
Diarrhea	□	□	□	Weakness	□	□	□
Genitourinary				**Psychiatric**			
Burning	□	□	□	Nervousness	□	□	□
Pain	□	□	□	Depression	□	□	□
Nocturia	□	□	□	Memory Loss	□	□	□
Sexual Function	□	□	□	Stress	□	□	□

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Disease/Condition	No	Yes	Other	Disease/Condition	No	Yes	Other
Respiratory				Depression	☐	☐	☐
Cough	☐	☐	☐	Diabetes or High Blood Pressure	☐	☐	☐
Sputum	☐	☐	☐	Emphysema	☐	☐	☐
Shortness of breath	☐	☐	☐	Heart Problems	☐	☐	☐
Wheezing	☐	☐	☐	Kidney Disease	☐	☐	☐
Asthma	☐	☐	☐	Liver Disease	☐	☐	☐
Blood Pressure Problems	☐	☐	☐	Osteoporosis	☐	☐	☐
Breast Cancer	☐	☐	☐	Seizures	☐	☐	☐
Colon Cancer	☐	☐	☐	Strokes	☐	☐	☐
Lung Cancer	☐	☐	☐	Thyroid Problems	☐	☐	☐
Ovarian Cancer	☐	☐	☐	Surgery	☐	☐	☐
Prostate Caner	☐	☐	☐	Allergies	☐	☐	☐
Uterian Cancer	☐	☐	☐	Medications	☐	☐	☐
Cholesterol Problems	☐	☐	☐				

Tobacco Use: ___Current Smoker ___Former Smoker ___Never Smoked How often:_______________
Alcohol Use: ☐ No ☐ Yes Recreational Drug Use: ___Cocaine ___Heroin ___Marijuana ___Other
Sexually Transmitted Disease: ☐ No ☐ Yes Notes:______________HIV Status: ___Positive __Negative

Disease/Condition	No	Yes	Relationship	Disease/Condition	No	Yes	Relationship
Blindness	☐	☐	____________	Macular Degeneration	☐	☐	______________
Cataracts	☐	☐	____________	Retinal Detachment/Tear	☐	☐	______________
Corneal Problems	☐	☐	____________	Cataract	☐	☐	______________
Diabetic Retinopathy	☐	☐	____________	Corneal Transplant	☐	☐	______________
Dry Eye	☐	☐	____________	Eye Muscle Surgery	☐	☐	______________
Eye Allergy	☐	☐	____________	Glaucoma Laser	☐	☐	______________
Eye Injury	☐	☐	____________	Glaucoma Surgery	☐	☐	______________
Floaters/Spots/Light Flashes	☐	☐	____________	LASIK/PRK	☐	☐	______________
Frequent Eye Infection/Stye	☐	☐	____________	Retinal Laser	☐	☐	______________
Glaucoma	☐	☐	____________	Retinal Surgery	☐	☐	______________
Glaucoma Suspect	☐	☐	____________	Retinal Injections	☐	☐	______________
Iritis/Uveltis	☐	☐	____________	RK Incisions	☐	☐	______________
Lazy/Crossed Eye	☐	☐	____________	Yag (Laser After Cataract)	☐	☐	______________

If you answered YES to any of the above or have a health or eye condition not previously covered, please explain:____

____

____________________________________ ____________________________

Doctor's Signature Date

Matthew T. Stanley, O.D.
Darcy D. Stanley, O.D.
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FINANCIAL & INSURANCE POLICY

1. Payment for services (including co-payment/ co-insurance/deductible) is due at time of service.
2. Verification of benefits by your insurance company and/or our office is not an absolute guarantee of payment. If your insurance denies payment for any service, we promise to notify you in a timely manner. However, full payment is due within 30 days of notification.
3. Not all services and products are necessarily covered by insurance. Furthermore, those that are covered may be dependant on your type of insurance, level of coverage, and previously exhausted benefits.
4. The parent who schedules/accompanies a minor to our office for an exam is responsible for payment. Our office cannot be involved in divorce settlements and/or custody disputes.
5. Eye Care Associates of Manhattan retains the right to pursue a Collection Agency's help in pursuing payment for outstanding accounts and will do so if a balance is more than 90 days past the date of first notification.
6. A returned check for non-sufficient funds will be assessed a $30.00 returned check fee. The responsible party is liable for the unpaid balance plus the returned check fee.

I hereby acknowledge that I have thoroughly read, understand, and agree to the terms of this policy regarding insurance coverage and fee payment.

Patient's Signature:____Date:____________________
(or) Signature of Patient's Representative:__________________________ Date:____________________
Relationship of Patient's Representative:____

HIPAA PRIVACY PRACTICES CONSENT

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of our office. You may revoke this consent at any time by notifying our office in writing, except to the extent that our office has already taken action. You have the right to request our office to restrict the manner in which your protected health information is used or disclosed. Our office is not required to agree to such request restrictions: however we will do our best to comply with such requests.

I hereby consent to the use and disclosure of my protected health information by Eye Care Associates of Manhattan, P.A., its work force, and its business associates for purposes of treatment, payment, and health care operations. I am aware I can request a copy of Eye Care Associates of Manhattan, P.A.'s HIPAA compliant "Notice of Privacy Practices" and it will be provided.

Patient's Signature:____Date:____________________
(or) Signature of Patient's Representative:__________________________ Date:____________________
Relationship of Patient's Representative:____

Effective Date: January 1, 2020

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Eye Care Associates of Manhattan, P.A.
Matthew T. Stanley, O.D., Privacy Official
1640 Charles Pl Ste 103 Manhattan, KS 66502
Phone: 785-776-9461 Fax: 785-776-9946
ecaofmanhattan@gmail.com

Patient Name:_________________________________
Address:_____________________________________
City, State & Zip Code:__________________________
Phone Number:_________________________________

I authorize Eye Care Associates of Manhattan, P.A. to release personal and health information identifying me (including diagnoses, treatment recommendations, and if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) to the following people:

Name:_____________________________Relationship to Patient:__________________
Name:_____________________________Relationship to Patient:__________________
Name:_____________________________Relationship to Patient:__________________
Name:_____________________________Relationship to Patient:__________________

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, by FAX or by email to Privacy Official noted above. This authorization will expire 1 year from the date signed or upon a minor's 18th birthday.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_______________________________ _______________________
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_______________________________ _______________________
Representative Signature Date