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

Patient #: _______

PRE-EXAM QUESTIONNAIRE

Name: ______________________ Sex: M____ F____ Today's Date: ____/____/____
Name you prefer to be called: ______________________ Home Phone: ____________
Street Address: ______________________ Daytime Phone: ____________
City: ____________ State: ________ Zip Code: __________ Cell Phone: ____________
Permanent Address (if different than above): ______________________
Email Address: ______________________ May we contact you by email with eye care newsletters and appointment reminders? Yes ______ No ______
Best way to contact me during the day: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email
Birth Date: ___/___/_____ Age: ___ Social Security #: ____-____-______ Last Eye Exam: ____________
Spouse/Parent's Name: ______________________ Marital Status: ____________
Name of Medical Doctor: ______________________ Last Medical Exam: ____________
Are other family members patients in our office? ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Brother/Sister
How were you referred to our office? ☐ Family ☐ Friend ☐ Phone Book ☐ Internet ☐ Radio ☐ _________

The following questions help our doctors and staff to provide you with the best possible vision care:

Occupation: ______________________ Full Time: ________ Part Time: ________
Employer: ______________________ Work Phone: ____________
Student: Y____ N_____ Full Time: _____ Part Time: _____ School: ____________
Major: ______________ Year: ____________
Hobbies/Sports: ______________________

FINANCIAL/INSURANCE INFORMATION:

Person financial responsible for this account: ______________________
Medical Insurance Company: ______________________ **(Please Present Insurance Card)**
Vision Insurance Company: ______________________ **(Please Present Insurance Card)**

If Vision and/or Medical Insurance is under the name of another person, please provide the following information so our office can file your claim in a timely manner.

Name of Insured: ______________________ Relationship to Patient: ____________
Insured's Place of Employment: ______________________
Social Security # of Insured: ____-____-______ Birth Date of Insured: ____/____/______
Address of Insured, if different than above: ______________________

***Vision plans cannot be billed for any patient being seen with a medical eye condition. These plans are strictly for well eye exams and do not apply if you have been diagnosed with a medical eye condition or complaints that might lead to a medical diagnosis. Most medical insurance policies do have some coverage for medical eye diagnoses.*

09/11

FINANCIAL & INSURANCE POLICY

Effective date: April 22, 2013

Eye Care Associates of Manhattan, P.A.
1441 Anderson Avenue
Manhattan, KS 66502
Phone: 785-776-9461
Fax: 785-776-9946
www.eyecaremanhattan.com
eyecaremanhattan@gmail.com

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.
6. A returned check for non-sufficient funds will be assessed a $30 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 requested restrictions; however we will do our best to comply with any 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____

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MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Today's Date: ____/____/____
Birth Date: ____/____/______ Height: __________ Weight: __________

MEDICAL/OCULAR HISTORY

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Hawaiian or Other Pacific Islander ☐ Indian ☐ White

Do you have any allergies to medications? ☐ No ☐ Yes If yes, list: ______________________________
____

List any medications you take (including oral contraceptives, over the counter medications, vitamins and home remedies):
____
____

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

Have you had any of the following: ☐ Crossed Eyes ☐ Lazy Eye ☐ Drooping Eyelid ☐ Dry Eyes ☐ Glaucoma ☐ Retinal Disease ☐ Cataracts ☐ Eye Infection(s) ☐ Eye Injury(ies) ☐ Other ______________________________

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 contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?______________________________

Type of contact lenses: ☐ Hard ☐ Soft ☐ Extended Wear (sleep in them) ☐ Other Are they comfortable? ☐ No ☐ Yes

How often do you replace your contacts? ____________ Do you ever sleep in your contacts? ☐ No ☐ Yes ☐ Sometimes

Are you interested in: Contact Lenses (if not already wearing) ☐ No ☐ Yes Eye Surgery (such as LASIK) ☐ No ☐ Yes

OCULAR/FAMILY HISTORY

Please note any history for yourself or immediate family (parents, grandparents, brothers, sisters, children - living or deceased) for the following conditions. Mark "self" in the relationship portion if it applies to you. Please use P for paternal and M for maternal family members. Ex. MGF for maternal grandfather.

Disease/Condition	No	Yes	Relationship	Disease/Condition	No	Yes	Relationship
Blindness	☐	☐	________	Diabetes	☐	☐	________
Cataract	☐	☐	________	Heart Disease	☐	☐	________
Crossed Eyes	☐	☐	________	High Blood Pressure	☐	☐	________
Glaucoma	☐	☐	________	High Cholesterol	☐	☐	________
Macular Degeneration	☐	☐	________	Kidney Disease	☐	☐	________
Retinal Detachment	☐	☐	________	Lupus	☐	☐	________
Eye Injury	☐	☐	________	Thyroid Disease	☐	☐	________
Arthritis	☐	☐	________	Cancer	☐	☐	________
				Other:	☐	☐	________

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

____

Do you use tobacco products? ☐ No ☐ Yes If yes, type / amount / how long: ______________________

Do you drink alcohol? ☐ No ☐ Yes If yes, type / amount / how long: ______________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type / amount / how long: ______________________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Other ____________

Review of Systems

Do you currently have, or have you ever had, any problems in the following areas?

SYSTEM	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (Skin)			
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes in Vision	☐	☐	☐
Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

SYSTEM	No	Yes	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Immunologic	☐	☐	☐
Psychiatric			
Depression	☐	☐	☐
Schizophrenia	☐	☐	☐
Bipolar	☐	☐	☐

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**

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Eye Care Associates of Manhattan, P.A.
Amy Hall, Privacy Official
1441 Anderson Ave.
Manhattan, KS 66502
785-776-9461 phone
785-776-9946 fax
ecaofmanhattan@gmail.com

Patient Name ____

Patient Address ____

Patient 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:

____________________________________ Relationship to Patient: ______________________

____________________________________ Relationship to Patient: ______________________

____________________________________ Relationship to Patient: ______________________

____________________________________ 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 the Privacy Official noted above. This authorization will expire 1 year from 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 Date

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

____ ______________________________

Representative Relationship to Patient