FELBER & ASSOCIATES L.L.C.
Dr. David R. Felber

TODAY'S DATE:____________________

Have you ever had an eye exam here before?____________________

LAST NAME:____________________ FIRST NAME:____________________ M.I.__________

BIRTHDATE:____________________ MALE_____ FEMALE_____

SSN:____________________

PHYSICAL ADDRESS:____________________

MAILING ADDRESS:____________________

CITY/ST:____________________ ZIP:____________________

HM PHONE: ____________________ CELL PHONE:____________________

EMAIL:____________________

EMPLOYER:____________________

RESPONSIBLE PARTY INFORMATION (if different):

NAME:____________________ RELATIONSHIP:____________________ DOB:__________

ADDRESS IF DIFFERENT:____________________

PHONE NUMBER____________________ EMPLOYER:____________________

SSN:____________________

WHEN WAS YOUR LAST EYE EXAM?____________________

DO YOU WEAR GLASSES NOW?____________________

HAVE YOU EVER WORN CONTACT LENSES?____________________

WHAT KIND OF CONTACTS DO YOU WEAR?____________________

DO YOU WANT AN EXAM FOR CONTACTS NOW?____________________

HEALTH INFORMATION: CHECK IF YOU HAVE A HISTORY OF:

____ **Heart Disease**
____ **High Blood Pressure**
____ **Heart Attack**
____ **High Cholesterol**

Weight Loss/Gain

____ **Diabetes**
____ **Thyroid Disease**

____ **Stomach Problems**
____ **Ulcers**

Kidney Disease
____ **Prostate Problems**

____ **Ear Problems**
____ **Sinus/Allergy Problems**
____ **Headaches**
____ **Migraines**

____ **Anemia**
____ **Hepatitis/Jaundice**
____ **Sickle Cell or Trait**
____ **Cancer**

____ **HIV**

Rosacea
____ **Skin Cancer**

____ **Arthritis**
____ **Back Problems**
____ **Neck Problems**

Stroke
____ **Seizures**
____ **Epilepsy**

____ **ADHD**
____ **Alcoholism**
____ **Drug Addiction**

Asthma
____ **Emphysema**

PLEASE TURN PAGE OVER

PHARMACY(List your pharmacies name and location and all of your meds can be imported from them):___________________________________

____

MEDICATIONS ALLERGIC TO:____

ARE YOU PREGNANT / NURSING?______________

MARITAL STATUS: SINGLE_____MARRIED_____ DIVORCED_____WIDOWED_____(REQUIRED BY INSURANCE)

SOCIAL HISTORY: Do you use: Tobacco: Y___ N___ Illegal Drugs: Y___ N___ **(REQUIRED BY INSURANCE)**

FAMILY HISTORY: (LIST ANY CONDITIONS THAT RUN IN YOUR FAMILY)_______________________________________

____

HOW DID YOU HEAR ABOUT US:____

INSURANCE INFORMATION:

	Primary		Secondary
Health Insurance Carrier:	______________________	/	______________________
Policy/Contract/SS Number:	______________________	/	______________________
Policy Holders LEGAL Name:	______________________	/	______________________
Policy Holders Date of Birth:	______________________	/	______________________
Policy Holders Employer:	______________________	/	______________________
Policy Holders Address: **(If Different than Responsible Party)**	______________________	/	______________________

	Primary		Secondary
Vision Insurance Carrier:	______________________	/	______________________
Policy/Contract/SS Number:	______________________	/	______________________
Policy Holders LEGAL Name:	______________________	/	______________________
Policy Holders Date of Birth:	______________________	/	______________________
Policy Holders Employer:	______________________	/	______________________
Policy Holders Address: **(If Different than Responsible Party)**	______________________	/	______________________

The above information is true to the best of my knowledge. Fees for professional services and materials are due at the time of service or when materials are ordered. Payment from my insurance is to be paid directly to Felber and Associates LLC. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. Final determination can only be made after the claim is processed. My signature below also acknowledges that I have been offered/read Felber and Associates Privacy Notice. I also understand that I am ultimately responsible for any charges incurred today, including those charges that my insurance company may deny. I authorize Felber and Associates LLC or my insurance company to release any information required to process my claims.

____**DATE:**______________________

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

<u>RETINAL SCANNING</u>

We have a state of the art device in our office that will scan the eye and the structures underneath. This is a non-invasive scan (OCT scan) that allows our doctor to see below the surface of the retina. This technology can allow us to see problems in the eye up to 10 years earlier than can be seen with a normal eye exam and dilation. In most cases this scan will replace the need for dilation. This procedure provides a permanent scan and image that can be reviewed and compared from year to year and track any changes in health.

The doctor strongly recommends that all patients have this procedure performed. **<u>If you choose not have the scan, then you must be dilated.</u>**

This scan is **<u>NOT</u>** covered by your health or vision insurance.

______ I choose the scan and agree to pay $25.00 to have this procedure done.

______ I do not want to have this procedure performed. I prefer to be dilated.

_____________________________ _________________

Signature Date

HIPAA Medical Information Release Form

Patient Name: ________________________________ Date:______________

Privacy regulations require us to have a release form signed by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and financial information. Each person you would like to have access to your information must be listed below.

Please print the name and relationship for each person you are authorizing access to your medical information and account balances.

Please choose an option below and sign when done.

____ "The person(s) listed below have access to my private information":

____________________________________ _________________________
Name Relation

____________________________________ _________________________
Name Relation

OR

____"I choose not to release my private information with anyone."

Patient Signature: _____________________________