Welcome to our office Clovis Vision Associates 1217 Pile St. Clovis, NM 88101 575-763-5522 www.clovisvision.com

Name________________ Birth Date________________ Gender M F

Address________________ City________________ State________ Zip________

Home Phone________________ Work________________ Cell________________ ❑check if ok to text

Employer /School________________ Occupation________________

Social Security #________________ E-Mail________________

Spouse/Parent________________ Today's Date________________

Health Insurance________________ Vision Insurance________________ Are you a new patient to our office? No❑ Yes❑

Insured's Name (if not patient)________________ Your Relationship to Insured________________

Insured's Employer________________ Insured's Birth Date________________

Your Language Preference: English❑ Spanish❑ **Your Communication Preference:** Email❑ Postal❑ Telephone❑ Text❑

Your Race/Ethnicity: African American❑ Asian❑ East Indian❑ Hispanic/Latino❑ Native: American/Alaskan❑ Native: Hawaiian/Pacific Island❑ White❑

List all medications and dosages: Check if none❑

List all drug allergies: Check if none❑

Who is your primary care physician?________________

Women—are you pregnant or nursing?

No❑ Yes❑ Due Date:

Review of Systems *(ROS)—Your personal health history*

	No	**Yes**	***Please circle all relevant items.***
Allergy	❑	❑	*Allergies*
Cardiovascular	❑	❑	*Vascular-Heart Disease, ↑Blood Pressure, ↑Cholesterol*
Constitutional	❑	❑	*Fever, Weight loss/gain*
Endocrine	❑	❑	*Diabetes, Thyroid, Gland Disease*
Gastrointestinal	❑	❑	*Liver, Hepatitis, Ulcer, Reflux*
Genitourinary	❑	❑	*Kidney, Bladder Disease*
Head	❑	❑	*Sinus, Eye, Ear, Nose, Throat*
Hematologic-Lymphatic	❑	❑	*Anemia, Blood Disease*
Immunologic	❑	❑	*Crohns, HIV, Herpes Zoster-Simplex*
Integumentary	❑	❑	*Lupus, Skin, Breast Disease*
Musculoskeletal	❑	❑	*Arthritis, Muscle Pain, Joint Pain*
Neurological	❑	❑	*Headache, Migraine, Seizures, MS*
Psychiatric	❑	❑	*Depression, Anxiety, Psychosis*
Respiratory	❑	❑	*Asthma, Bronchitis, Emphysema*

Please note any other significant personal health problems:

Do you currently wear? Glasses❑ Contact Lenses❑ None❑

Have you had any eye surgery? No❑ Yes❑ If yes, please explain:

Past, Family, Social History *(PFSH)—Your family health history*

List affected persons--parents, grandparents, siblings, aunts, uncles—do __not__ include your spouse, children, or non-blood relatives.

Condition	**No**	**Yes**	
Blindness	❑	❑	________
Cataracts	❑	❑	________
Color Deficiency	❑	❑	________
Glaucoma	❑	❑	________
Macula Disease	❑	❑	________
Retina Disease	❑	❑	________
Arthritis	❑	❑	________
Cancer	❑	❑	________
Diabetes	❑	❑	________
Heart Disease	❑	❑	________
Kidney Disease	❑	❑	________
Liver Disease	❑	❑	________
Thyroid Disease	❑	❑	________
Hypertension	❑	❑	________
HIV / AIDS	❑	❑	________
Other:			

CMS requires us to ask the following social history questions.

Tobacco Use?	No never ❑	Yes now❑	Yes past❑
Alcohol Use?	No ❑	Yes now❑	
Narcotic Use?	No ❑	Yes now❑	
STD?	No ❑	Yes now❑	

Height________________ Weight________________

Do you have any of these eye symptoms?

Redness❑, Dryness❑, Itch❑, Floaters❑, Eye Pain❑, Flashes❑ Watering❑, Light-Sensitivity❑, Headaches❑, Double Vision❑ Sudden Vision Loss❑, Blurred Vision❑

Method of Payment

Cash❑ Check❑ Insurance❑ Medicare❑ Credit/Debit Card❑

Are You Interested In?

Contact Lens❑ Sports/Safety Rx❑ Refractive Surgery❑ Therapeutic Services❑ Other❑

- **Health Information Disclosure:** In the course of providing service to you, we (Clovis Vision Associates) create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office.
- **Privacy Policy:** We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. When you sign this document you also acknowledge that Clovis Vision Associates has made available to you a copy of their Privacy Practices Policy.
- **Reminders/Missed Appointments:** We will attempt to remind you of appointments a day or more prior to your scheduled time, we must have a current/working telephone number to contact you. If you cannot be contacted we may find it necessary to cancel your appointment. Patients who no-show for appointments, without notification, may be excluded from making future appointments.
- **Payment Policy:** Payments for services are required at the time of service. Patients with insurance must inform us of insurance coverage before any services are rendered. Patients are responsible for any and all unpaid insurance balances. Payments for materials are due upon dispensing. Clovis Vision Associates does not offer charge accounts or extended payment plans.
- **Pupil Dilation:** Your eye examination may include pupil dilation. Pupil dilation could significantly affect your ability to drive, blur your vision, and/or make you more sensitive to light—dilation duration is typically 2-6 hours. Dilation allows a more thorough examination of your eye health—refusal to allow dilation may significantly impede our ability to accurately determine your eye health. Contact us immediately if you experience unusual post-dilation side effects such as swelling, pain, or unusually prolonged blurred vision. If you do not wish to be dilated, please inform your doctor.
- **Spectacle Lenses:** No lens is unbreakable. Polycarbonate is currently the safest and most shatter resistant material available; glass lenses are the least safe and the most likely to break—Clovis Vision Associates discourages the use of glass spectacle lenses.

I HAVE READ THIS CONSENT FORM AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I ALSO ACKNOWLEDGE CLOVIS VISION ASSOCIATES HAS MADE AVAILABLE TO ME A COPY OF THEIR PRIVACY PRACTICES POLICY. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF ALL FEES ASSOCIATED WITH THE SERVICES AND MATERIALS PROVIDED, ON MY BEHALF, BY THIS OFFICE. I UNDERSTAND THE POTENTIAL RISKS AND BENEFITS ASSOCIATED WITH PUPIL DILATION AND I UNDERSTAND THE POTENTIAL RISKS ASSOCIATED WITH THE REFUSAL TO ALLOW PUPIL DILATION. I UNDERSTAND THE GREATER RISK INHERENT IN THE WEARING OF GLASS SPECTACLE LENSES.

Dated____________________ Patient's Signature____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient____________________________ Print Name________________________________

Source of Authority____

Office Use Only

\# IOP BP Pulse PD __________distance __________near

Height Weight New ❑ Established ❑

Entering R_x OCT: OD OS OU

OD CC______________________________ Ganglion

Macula

OS OPTOMAP Y N OM+ FAF NFL/ONH

Progression

ADD+

❑None ❑SV ❑BIF ❑TRI ❑PAL ❑OTC *None MC VSP DV TRI Other*__________