NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Contact Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Guardian Information *(if patient is under 18 years of age)*

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Patient Information

Gender _____
Date of Birth _____
Social Security No. _____

Primary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Secondary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Additional Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- ◯ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
- ◯ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- ◯ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____

PATIENT HISTORY

Vision Correction History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Eye pain and/or soreness ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Mucous discharge ☐
- Redness ☐
- Sandy or gritty feeling ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

Glasses History *(check all that apply)*

What glasses do you own?

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Other: ☐
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

How many hours per day do you spend using a computer? _____

Check any that apply

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

Contact Lens History *(check all that apply)*

- What brand of contacts do you wear? _____
- How old are your current contacts? _____
- How often do you replace them? _____
- What solution do you use for soaking? _____
- What is your typical wearing schedule? _____

Check any that apply

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

Allergies *(please list)*

- None ☐

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list all eye conditions you have experienced:

Surgeries:

Do you have any of the following?

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Multiple sclerosis (MS) ☐

Other:

Referral Information

Why did you visit us?

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

Keep in touch

Facebook email _____

@Twitter handle _____

Questions and notes

Do you have a question? Concern? We want to know.

Tulsa Vision Clinic, Inc.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I. Patient information (For Patient Whose Information Will Be Obtained or Released) PLEASE PRINT

Name: _____ **Date of Birth:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Area code & phone number: _____ **Date:** _____

If you want your medical information released to family members or friends, please list names and relationships here:

_____ _____
Name/Relationship **Name/Relationship**

_____ _____
Name/Relationship **Name/Relationship**

I authorize Tulsa Vision Clinic to (check one) □ Obtain information from □ Release information to

_____ _____
Name of person(s), provider or facility **Relationship**

_____ _____
Address, City, State, Zip Code **Area code, phone number**

Purpose of Request (please check appropriate box) □ Healthcare □ Insurance coverage □ Legal □Personal □ Other
Information to be Obtained or Released (check all that apply): □ Medical Records □ Billing Records □ Other

If other, please specify: _____
A. Covering services between _____ **and** _____ **(insert dates or "all")**
B. This authorization will expire (must choose one) □ 12 months from the date signed, OR □ Other

II. ACKNOWLEDGEMENTS AND SIGNATURES

A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Tulsa Vision Clinic.
D. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.
E. Right to Revoke-I understand I may change this authorization at any time by writing to Tulsa Vision Clinic. I understand I cannot restrict information that may have already been shared based on this authorization.
F. This document must be signed by the patient or the patient's legal representative.

_____
Patient or legal representative

Signature: _____ **Date:** _____
Printed Name: _____ **Relationship to Patient:** _____ **(if applicable)**

4433 S. Harvard Ave., Tulsa, Oklahoma 74135◦ Phone 918-743-6334 ◦ Fax 918-743-6369

Retinal Image Consent Form

Tulsa Vision Clinic is proud to provide our patients with the most highly advanced technology available in retinal screening today! Our ability to view your internal retinal health is now dramatically improved with OptoMap.

Dr. Cheatham strongly recommends that all patients of Tulsa Vision Clinic have this procedure done to allow him to utilize all tools available to assess the health of the eyes, and especially if any of the following apply:

- Diabetes
- High Blood Pressure
- Frequent or severe headaches
- High Nearsightedness
- Symptoms of flashes or floaters
- Personal or family history of glaucoma
- Personal or family history of retinal holes/tears or retinal disease

The entire process takes less than 5 minutes to complete in most cases. There are no side effects to this procedure like those normally associated with dilation, such as sensitivity to light and/or blurry vision. No drops are necessary to have the OptoMap done. The additional fee for this procedure is only $39.00.

Pease check one:

- I wish to have the OptoMap exam done today
- I decline the OptoMap exam today
- I would like to have the OptoMap scheduled for another day. (To be done within 30 days of the exam)

Patient/Parent Signature: _____

Date: _____

If patient is a minor (under 18 years old) a parent/guardian must sign this form.