Terri D. Eachus, O.D.
204 E. College Blvd.
Roswell, NM 88201
(575)625-9800 Office- (575)624-1724 Fax
eyecatchers@qwestoffice.net

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____
Patient Address: _____
Patient Phone Number(s):_____

I authorize the professional office of my optometrist name above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [Name(s) or class(es) of recipients]:
3. The Purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you is you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed and provided in this authorization, the recipient often has no legal duty to protect it's confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date:_____

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: _____

Eye Catchers
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Welcome to the office of Dr. Terri D. Eachus at Eye Catchers, we are pleased that you have selected our office and staff for your eye care needs. Unfortunately we do not take insurance. Full payment is required for ALL services performed or service provided by Dr. Eachus and staff at the time of service. We DO NOT accept insurance on assignment but will be happy to help you file your insurance claim for you, they will reimburse you the patient directly. _____ **INT**

An appointment will not be required to dispense, adjust or repair your eye-wear. You will however be charged reasonable fees for any parts that are required for repair and maintenance of your eye-wear. All eyeglass orders will require a deposit of ½ of the total purchase price before eye-wear can be ordered, with the remaining balance due at the
time glasses are picked up. _____ **INT**

We DO NOT take medicare on assignment. We will file the medicare claim on your behalf. Reimbursement will be paid to you. We DO NOT know what portion, if any, that medicare will reimburse to you, as we are not a medicare provider. _____ INT

Once Again, thank you for choosing our office. We look forward to caring for you and your family visual needs.

(Please remember that every child should have an eye exam by the age of 3)

WE DO NOT TAKE INSURANCE

PATIENT HISTORY AND INFORMATION

PLEASE TAKE A MOMENT TO REVIEW/COMPLETE THE FOLLOWING INFORMATION. PLEASE PRINT CLEARLY. IF YOU HAVE QUESTIONS, PLEASE DO NOT HESITATE TO ASK.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Female ☐ Male

First Name Middle Last Name Preferred Name

Street Address City State Zip

Social Security Number Birthdate Age Home Phone Work Phone Cell Phone

Email Guardian Person Responsible for Account

Employer Occupation Emergency Contact Emergency Phone

Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced ☐

How were you referred to our office?

☐ Phonebook ☐ Patient ☐ Web ☐ Other_____

Primary Insurance Information (reminder: we are not a provider)

Insurance Company Member ID# Group #

Primary Insured Name Birthdate Home Phone Cell Phone

Patients Relationship To Insured ☐ Self ☐ Child ☐ Spouse ☐ Other:_____

Primary Care Physician

Primary Care Physicain and Clinic Name

Address City State Zip Phone

When was your last Health Exam?_____

Health History

What is the main reason for today's exam?

When was your last Eye Exam? _____ Doctor_____ Phone_____

Past Illnesses or Injuries: _____

Past Surgeries_____

Medications- List all medication you take, prescription and non-prescription, and the dosage(or attatch list)	
☐ I do not take any medications Pharmacy:_____	
Medication	Dosage

Any Allergies to Medications_____

Eye History

Glaucoma	Yes or No	Dryness	Yes or No	Crossed Eyes	Yes or No
Cataract	Yes or No	Excess Tearing/watering	Yes or No	Blurred Vision Distance	Yes or No
Macular Degeneration	Yes or No	Eye Pain or Soreness	Yes or No	Blurred Vision Near	Yes or No
Retinal Detachment	Yes or No	Foreign Body Sensation	Yes or No	Distorted Vision (halos)	Yes or No
Color Blindness	Yes or No	Infection of Eye or Lid	Yes or No	Double Vision	Yes or No
Headaches	Yes or No	Itching	Yes or No	Floaters or Spots	Yes or No
Glare/Light Sensitivity	Yes or No	Mucous Discharge	Yes or No	Fluctuating Vision	Yes or No
Tired Eyes	Yes or No	Drooping Eyelid	Yes or No	Loss of Vision	Yes or No
Amblyopia (Lazy Eye)	Yes or No	Redness	Yes or No	Loss of Side Vision	Yes or No
Burning	Yes or No	Sandy or Gritty Feeling	Yes or No	Other:	

General Health Condition

Fever	Yes or No	Respiratory(Asthma)	Yes or No	Anxiety or Depression	Yes or No
Weight Loss	Yes or No	Gastrointestinal	Yes or No	Thyroid	Yes or No
High Cholesterol	Yes or No	Kidney	Yes or No	Blood/Lymph	Yes or No
Ears, Nose, Throat	Yes or No	Muscles, Bones, Joints	Yes or No	Seasonal Allergies	Yes or No
Cardiovascular Heart	Yes or No	Skin	Yes or No	Pacemaker of the heart?	Yes or No
Sleep Apnea	Yes or No	Diabetes	Yes or No	Are You Pregnant?	Yes or No
High Blood Pressure	Yes or No	Neurological	Yes or No	Are You Nursing?	Yes or No
Arthritis	Yes or No	Cancer:_____	Yes or No	If yes: What Kind :_____	

Family History

Lazy Eye (Amblyopia)	Yes or No	Retinal Detachment	Yes or No	High Blood Pressure	Yes or No
Blindness	Yes or No	Eye Turn (Strabismus)	Yes or No	Kidney Disease	Yes or No
Cataracts	Yes or No	Arthritis	Yes or No	Lupus	Yes or No
Color Blindness	Yes or No	Cancer	Yes or No	Stroke	Yes or No
Glaucoma	Yes or No	Diabetes	Yes or No	Thyroid Disease	Yes or No
Macular Degeneration	Yes or No	Heart Disease	Yes or No	Other	Yes or No

Tobacco Use ☐ Yes ☐ No How long have you smoked?_____	Daily ☐ Weekly ☐ Less ☐ How many packs a week?_____	Chewing ☐ Cigar ☐ Cigarette ☐ Smokeless
Alcohol Use ☐ Yes ☐ No	Daily ☐ Weekly ☐ Less ☐	Beer ☐ Liquor ☐ Wine ☐ Other:
Exercise Activity ☐ Yes ☐ No	Moderate ☐ Vigorous ☐ Sedentary ☐ Days/week: _____	Smokers at home: Yes ☐ No ☐
Caffeine use ☐ Yes ☐ No	Daily ☐ Weekly ☐ Less ☐	Coffee ☐ Tea ☐ Soda ☐ Other:

Spectacle Lens History

Do you Currently wear Glasses? Yes or No Since_____

Type of Glasses ☐ Full Time ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ Single Vision ☐ Bifocals ☐ Trifocal ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? Yes or No _____

Do you wear Sunglasses? Yes or No

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes or No

Have you ever tried to wear contact lenses? Yes or No Since_____

Type and brand of contact lenses? _____ Todays Wearing time? _____

How often do you throw away?_____ Sollution Used?_____

How many hours/day(wear time)?_____ How many days a week?_____

Please rate the following on a scale of 1-10 1- being you like them, 10- being you dislike them)_____

If no longer wearing, Reason Why?_____

Comments:

_____ _____

Patient Signature Date

PRIVACY PRACTIVES ACKNOWLEDGEMENT FORM

TERRI D EACHUS, O.D.

AS OUR PATIENT, YOU HAVE THE RIGHT TO ADEQUATE NOTICE OF THE USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION.

YOU HAVE THE RIGHT TO KNOW OUR LEGAL DUTIES REGARDING OUR POLICIES AND PROCEDURES RELATING TO THE USE AND DISCLOSURES OF YOUR HEALTH INFORMATION.

I ACKNOWLEDGE RECEIPT OF THE NOTIFICATION OF PRIVACY PRACTICES:

NAME: _____

SIGNATURE: _____DATE:_____

I CONSENT TO DIAGNOSIS AND TREATMENT BY: TERRI D. EACHUS, O.D. :

NAME: _____

SIGNATURE:_____DATE:_____