Welcome to LIBERTY EYE CARE!

FULL, LEGAL Name: _____ Preferred Name: _____ Today's Date: _____

Birthdate: _____ Street Address: _____

Age: _____ City, State, Zip: _____

Email Address (legible): _____ Prefer: ❑ email ❑ text

HOME Phone: _____ **MOBILE** Ph: _____ **WORK** Ph: _____

Sex: ❑ male ❑ female Employer: _____ Type of work: _____

Primary Medical Physician: _____ Office Location: _____

Emergency Contact/Guardian: _____ Their Phone: _____

Which helped you choose us? ❑ Web search ❑ Yelp ❑ Newspaper Ad ❑ Other Ad ❑ Friend/family ❑ Other

Do you take any medications? ❑ yes ❑ no If yes, please provide a separate list, or list them here: _____

Are you allergic to any medications? ❑ yes ❑ no If yes, please list them: _____

	YES	NO		YES	NO		YES	NO
Blindness	❑	❑	Eye Injury	❑	❑	Lupus	❑	❑
Temporary Blindness	❑	❑	Diabetes	❑	❑	Rheumatoid Arthritis	❑	❑
Crossed or Lazy Eye	❑	❑	High Blood Pressure	❑	❑	Mental Impairment	❑	❑
Glaucoma	❑	❑	Heart Disease	❑	❑	Hepatitis or HIV	❑	❑
Macular Degeneration	❑	❑	Thyroid Disease	❑	❑	Cancer	❑	❑
Retina Disease	❑	❑	Nicotine Use	❑	❑	Other: _____		
Cataract	❑	❑	Past Nicotine Use	❑	❑	Pregnant or Breastfeeding?	❑	❑

► Please list any health changes that we should be aware of: _____

► Please indicate **where** and **when** your last eye exam was: _____

	YES	NO		YES	NO	
History of Eye Surgery?	❑	❑	Wear Glasses?	❑	❑	Age of present glasses lenses: _____
Wear Contacts?	❑	❑	Sleep in Contacts?	❑	❑	Age of **current** Contacts: _____
Want Contact Prescription?	❑	❑	Interested in LASIK?	❑	❑	Contact Solution: _____

► Regarding your **FAMILY** history (siblings, parents, grandparents, children), has anyone had any of the following: **Blindness, Glaucoma, Macular Degeneration, Retina Disease, Diabetes, or other conditions significant to eye health**? If so, please list the relationship and condition: _____

DIABETES STATUS QUESTIONNAIRE

Primary Diabetes Physician: _____

How long have you had Diabetes? _____ ❑ Type I (juvenile onset) ❑ Type II (adult onset)

Do you take Insulin? ❑ yes ❑ no What (other) Diabetes medications do you take? _____

How well controlled is your Blood Glucose? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Record your last Sugar measurement: _____ When? _____Last Hemoglobin A1c: _____ When? _____

Have you been diagnosed with diabetic eye disease? ❑ yes: _____ ❑ no

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FEE-FOR-SERVICE NOTICE:

(Does not apply with Membership option) The level of exam we provide depends on the purpose for your visit. A "Routine Vision Exam" ($110) only applies if you are having no eye problem besides needing a new vision prescription. **If you are presenting with a problem involving a medical condition related to your eyes (e.g., diabetes, glaucoma, cataracts, etc.), higher fees will apply.**

COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. These methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Liberty Eye Care and/or Dr. Selander, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Dr Selander.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Dr. Selander about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI) BY NON-SECURE MEANS

I consent to allow Dr. Selander to use unsecured email and mobile phone text messaging to transmit to me the following PHI:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Personal information as initiated by me, to which Dr. Selander may respond

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

I acknowledge and consent to the notices contained on this form, including the fee-for-service and non-secure means of communication notices.

_____ _____

Patient (or Parent/Guardian) Signature Date

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge Dr. Eric M. Selander's posted Notice of Privacy Practices with an effective date of September 25, 2014. A copy of this Notice is readily available to me. My understanding of this Notice is satisfactory.

I authorize the practice of Eric M. Selander, O.D. to release my PHI to the following individuals or categories of people:

Their name:_____ Relationship: _____

Their name:_____ Relationship: _____

I consent to the acknowledgment of notice of privacy practices.

_____ _____

Patient (or Parent/Guardian) Signature Date