BUCKEYE FAMILY EYE CLINIC, INC.

Dr. Tausha L. Barton
Optometrist

As a patient of our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to complete your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this information in order to give you the best care possible.

- ☐ **Completed Welcome to the Office Form**: This diagnostic information includes personal and family information needed to complete your file, as well as your current eye health and vision status. Your responses will guide our doctor and staff, and remind us to address any significant issues during your visit.

- ☐ **Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a "whole person" rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication. **Please be sure to complete this information entirely *prior* to arriving at our office as it is the first part of your examination.**

- ☐ **Insurance cards or claim forms:** For any **optical** and/or **medical insurance** you may be covered by. (Even for "routine" visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination.) You must provide all insurance cards at the time of your visit.

- ☐ **Eyeglasses:** Please bring **ALL** pairs of eyeglasses you currently have (even if they seem to be incorrect, broken or not worn often) including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

- ☐ **Contact Lenses:** If you are getting a contact lens exam, it is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you are new to our office and wear planned replacement or disposable lenses, it is very helpful and will save you time if you bring along your cartons or lens packets that indicate the lens series, power, manufacturer, etc. or your written contact lens prescription.

- ☐ **Eye drops, ointments, etc:** Please place any eye drops or ointments that you use in a small bag and bring it along with you. Your doctor will review whether these are appropriate or if a better option is available.

- ☐ **Dilation Explained**: The doctor uses drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at a near (reading) distance. Therefore, if you want new eyewear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection. If you think you may feel uncomfortable driving after dilation, we recommend you bring someone to drive.

- ☐ **Photo ID:** Please bring your photo ID. If a minor child is the patient, bring the parent's photo ID. Insurance companies are asking that we verify identification due to the increasing problem with identity theft and insurance fraud.

- ☐ **Payment**: Payment is due at the time of service unless other arrangements have been made prior to the day of your appointment. We accept cash, checks, money orders, Visa and Mastercard.

- ☐ **Arrival:** Please arrive promptly at your scheduled appointment time with all of the above information already completed. We request 24 hours notice (but a minimum of 4 hours is required) to reschedule your appointment. Please be considerate of this so your reserved time can be given to another patient needing to be seen. If proper notice is not given, you are considered a missed appointment. If you arrive 15 minutes after your scheduled appointment time, you may be asked to reschedule and then marked as a missed appointment. If you have three missed appointments on record you will be dismissed as a patient from our practice.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner. We look forward to your visit!

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www.buckeyefamilyeyeclinic.net

Buckeye Family Eye Clinic, Inc.
Dr. Tausha L. Barton

WELCOME TO OUR OFFICE

Patient Information

Last ____________________________________
First ___________________MI _____________
Name Used/Nickname ______________________
Sex M F
Race (If multiracial, list races)________________
Date of Birth __________________Age ________
PO Box__________________________________
Street Address____________________________
City _____________ State __________________
Zip Code _________________________________
Home Phone ______________________________
Cell Phone _______________________________
Work Phone ______________________________
Email Address _____________________________
Patient's SSN _____________________________
Employer (or School) _______________________
Business/School Address____________________
City, State, Zip____________________________
Occupation (or Grade) ______________________
Student ❑ Full Time ❑ Part Time ❑ Not
Driver's License #__________________________
Marital Status ❑ Single ❑ Married ❑ Divorced
❑ Widow ❑ Legally Separated
Spouse__________________________________
Spouse's Employer__________________________
Spouse's Business Phone#____________________

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative ____________________
If not referred, how did you choose our office?
❑ Another Dr., If so, who?______________
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____________
❑ Web Page: Which Web Site? _______________
❑ Other ________________________________

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Other
Name____________________________________
SS#_____________________________________
Birthdate__________________________Age_______
Phone___________________Cell_______________
Street____________________________________
City, State, Zip____________________________
Employer_________________________________
Business Phone____________________________

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____________________________
Subscriber Name_____________________________
Subscriber SSN_________________________
Subscriber Birth Date_________________________

Primary Medical Insurance_____________________
Subscriber Name_____________________________
Subscriber SSN_________________________
Subscriber Birth Date_________________________

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer? If yes, please complete computer questionnaire.
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have uncomfortable glasses?
❑..have eye itchiness?
❑..have family members in need of eyecare?
❑..have children? Ages___________________________
❑..have tearing, burning or grittiness?
❑..have flashes of light or floaters?
❑..have sunlight sensitivity?
❑..have trouble seeing at night?

The mission of Buckeye Family Eye Clinic, Inc. is to provide a lifetime of ocular health and visual performance to improve our patient's quality of life. We strive to deliver superior customer service with thorough and personal eye care in a timely, efficient and knowledgeable manner assisting you based on your individual needs.

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Constitution		
Fatigue	❑	❑
Insomnia	❑	❑
Sudden Weight Gain	❑	❑
Sudden Weight Loss	❑	❑
Other_______________		
Cardiovascular		
Angina	❑	❑
Arrhythmia	❑	❑
Congestive Heart Failure	❑	❑
Coronary Artery Disease	❑	❑
High Cholesterol	❑	❑
High Blood Pressure	❑	❑
Is it under control?	❑	❑
Heart Attack	❑	❑
Stroke	❑	❑
Other_______________		
Ear/Nose/Mouth/Throat		
Ear Infections	❑	❑
Hearing Aid	Right Left	Both
Sinusitis	❑	❑
Other_______________		
Respiratory		
Asthma	❑	❑
COPD	❑	❑
Bronchitis	❑	❑
Emphysema	❑	❑
Lung Cancer	❑	❑
Sarcoid	❑	❑
Shortness of Breath	❑	❑
Tuberculosis	❑	❑
Other_______________		
Gastrointestinal		
Chrones Disease	❑	❑
Colitis	❑	❑
Diverticulitis	❑	❑
Gastric Reflux	❑	❑
Hepatitis	❑	❑
Type A, B or C (circle one)		
Ulcers	❑	❑
Other_______________		

Genitourinary	**Yes**	**No**
Dialysis	❑	❑
Enlarged Prostate	❑	❑
Incontinence	❑	❑
Kidney Failure	❑	❑
Kidney Stones	❑	❑
Ovarian Cysts	❑	❑
Ovarian Cancer	❑	❑
Prostate Cancer	❑	❑
Uterine Cancer	❑	❑
Possible you are pregnant	❑	❑
If yes, due date____________		
Currently breastfeeding	❑	❑
Other_______________		
Musculoskeletal		
Arthritis	❑	❑
Cerebral Palsy	❑	❑
Gout	❑	❑
Muscular Dystrophy	❑	❑
Rheumatoid Arthritis	❑	❑
Other_______________		
Integumentary (Skin)		
Eczema	❑	❑
Psoriasis	❑	❑
Skin Cancer	❑	❑
Type_______________		
Location____________		
Other_______________		
Neurological		
Frequent Headaches	❑	❑
Bell's Palsy	❑	❑
Multiple Sclerosis	❑	❑
Epilepsy	❑	❑
Migraines	❑	❑
Other_______________		
Psychiatric		
Anxiety	❑	❑
Bipolar	❑	❑
Depression	❑	❑
Dementia	❑	❑
Panic Episodes	❑	❑
Schizophrenia	❑	❑
Other_______________		
Endocrine		
Diabetes	❑	❑
Type I, Type II, Borderline, Gestational (circle)		
Thyroid	❑	❑
Slow, Fast (circle one)		
Other_______________		

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Hematologic/Lymphatic		
Anemia	❑	❑
Leukemia	❑	❑
Lymphoma	❑	❑

Other____

	Yes	No
Allergic/Immunologic		
HIV	❑	❑
Lupus	❑	❑
Seasonal Allergies	❑	❑

Spring Summer Autumn Winter (circle)

Do you get itchy, red, watery eyes? Y N

Other____

Patient Surgical History

Have you had any surgeries? If so list the approximate year, procedure, and surgeon.
(e.g. 1974; Gall Bladder; Smith, John)

❑ No surgeries

Year	Procedure	Surgeon
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________
_________	____________________	_______________

If more space is needed, please attach additional paper.

Past/Present Ocular History

Have you ever been diagnosed or treated for the following eye problems?

	Yes	No
Glaucoma	❑	❑
Cataracts	❑	❑
Macular Degeneration	❑	❑
Eye Injury	❑	❑
Retinal Disease	❑	❑
Other Disease	❑	❑
Blindness	❑	❑
Strabismus/Eye Turn	❑	❑
Amblyopia	❑	❑
Diabetic Retinopathy	❑	❑
Dry Eye	❑	❑
Refractive/Glasses/Contacts	❑	❑

Other____

Date of last eye exam________________________________

By Whom?____

Circle or check the following

❑ I have never worn glasses

Glasses worn: Full time Distance Near

Glasses: Single Vision Lined Bifocal Lined Trifocal No-line Bifocal/Trifocal

If you wear bifocals or trifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

Contact Lenses : Daily Wear Extended Wear

Contact Lenses: Distance only Monovision Bifocal

What kind?____

Solutions used_____________________________________

How often are you supposed to replace your contacts?

____

How old is the current contact lenses that you are wearing?

____

How many hours each day do you usually wear your contact lenses?___________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If interested in colored contact lenses, what color?_______

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Social History

Tobacco Use
- ❑ Never
- ❑ Cigarettes Discontinued (List Year) _______________
- ❑ Cigarettes (Approximate Packs Per Day ____________
- ❑ Cigars (Approximate Number Per Week) ___________
- ❑ Pipe (Approximate Number Per Week) _____________
- ❑ Chewing Tobacco (Approximate Cans Per Week) ___

Drug Use (List frequency of use):
- ❑ Never
- ❑ Discontinued (List Drugs & Year Discontinued)

____

- ❑ Cocaine _______________________________________
- ❑ Crack ____
- ❑ Heroin ____
- ❑ Marijuana _____________________________________
- ❑ Methamphetamine ______________________________
- ❑ Speed ____

Alcohol Use (Check Type & List Number of Drinks Per Week)
- ❑ Never
- ❑ Discontinued (List Year Discontinued)_____________
- ❑ Beer ___________________________
- ❑ Liquor __________________________
- ❑ Wine ___________________________

Occupation_____________________________________

Hobbies _______________________________________

____

Family Medical/Eye History (Check all that apply)

Is there a family history of any of the following:

❑ No ❑ Yes (Please check boxes)

Please enter Relationship (example: Grandma, Uncle, etc.)
Also put whether relative is Mother or Father's side.

Glaucoma	❑__________________________
Cataracts	❑__________________________
Macular Degeneration	❑__________________________
Retinal Disease	❑__________________________
Other Disease	❑__________________________
Blindness	❑__________________________
Strabismus/Eye Turn	❑__________________________
Amblyopia	❑__________________________
Diabetes	❑__________________________
Cancer	❑__________________________
Heart Disease	❑__________________________

Medical Doctor

Medical Doctor___________________________________
Address____
City, State, Zip__________________________________
Phone____
Fax____
When was your last visit to your medical doctor?

____

What was the reason that you were seen?

____

Do we need to send a report to this doctor regarding your examination with us? (e.g. diabetic eye report)
Circle: Yes No

Allergy

❑ Check if no known drug or environmental allergies of any kind

Allergy List Medication or Allergen (Penicillin, Pollen, Bees, Shellfish)	**Type** (Drug, Environmental, Insect, Food)	**Onset** (List Year, Season, etc.)	**Reaction** (Hives, Anaphylactic Shock, Nausea, Anxiety)	**Severity** (Mild, Moderate, Severe)

The information in this confidential case history form is critical to the evaluation of your vision and health.

Medications

In order to keep your health safe, your Doctor needs to know ALL prescription, over-the-counter medications, vitamins, and herbal and nutritional supplements that you are taking. This also includes eye drops and ointments. Please be sure to fill in this information completely.

❑ Check if no medications are taken of any kind

Name of Medication	**Approximate Year Began Taking**	**Dosage of Medication** (20 micrograms, 800 milligrams)	**Form** (tablet, syrup, spray, injectable, inhaler, cream, eye drop, eye ointment)	**Route/How Taken** (mouth, nasal, ocular)	**How many and how often taken** (e.g. 1 pill 2 times each day; 2 pills 1 time each day; as needed, etc.)	**Use/Reason for Taking Medication** (High Blood Pressure, Diabetes)

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of the staff, responsible for any errors or omissions that I have made in the completion of this form. **I attest that the information I provided is true and correct to the best of my ability and knowledge.**

Signature of patient (*Parent or Guardian if minor)*________________________________ Date________________

Printed name of signature above________________________________Relationship *(to minor child)*_____________

FOR OFFICE USE ONLY: Reviewed by:____ Date_________________

Patients: Please complete the next page.

Fees & Payments

We make every effort to keep down the cost of your medical care. You can help by paying in full upon the completion of each visit. If you have any vision and/or medical insurance we will be glad to fill out the proper forms or file the claim for you, but please complete the identifying information within this paperwork.

If you are using insurance coverage for today's visit--this is a contract between you and your insurance company, not Buckeye Family Eye Clinic, Inc., or Dr. Tausha L Barton. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures or items and others pay a percentage of the charge. **I certify that the insurance information that is on this form or provided to this office is accurate. I understand I am financially liable for any deductible amount, co-insurance & non-covered services or any other balance not paid by my insurance company(s). I understand that you may bill me if my insurance company takes longer than 90 days to pay your office. If my insurance company denies payment, I agree to be personally responsible for payment. If I have no insurance, I understand that I am responsible for the entire balance of services and products provided. I will be responsible for all collection costs, attorney's fees, and court costs.**

Signature of patient (*Parent or Guardian if minor)*______________________________ Date_______________

Printed name of signature above______________________________Relationship *(to minor child)*____________

Insurance Authorization

This signature on file is my **authorization for the release of information necessary to process my insurance claim**. I hereby authorize payment to this doctor or office named of the benefits otherwise payable to me. This signature may be used for all insurance claims unless revoked in writing.

Signature of patient (*Parent or Guardian if minor)*______________________________ Date_______________

Printed name of signature above______________________________Relationship *(to minor child)*____________

Privacy Practices

I hereby acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient (*Parent or Guardian if minor)*______________________________ Date_______________

Printed name of signature above______________________________Relationship *(to minor child)*___________

Credit Card

If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will refund to you any portion that is due to you.)

Please enter your credit card number and expiration date.
CC#:________________________________Security Code (on back of card)_________Expiration Date________

Signature__________________________________Printed name______________________________________