

**DIRECTIONS FOR COMPLETING
NEW PATIENT PAPERWORK**

PATIENT INFORMATION FORM

If you have insurance you will be using, just bring your insurance card in when you come for your exam. It is not necessary to fill out the Insurance Section. We will make a copy of your card.

HEALTH HISTORY

Fill out everything to the best of your ability. Be sure to include ALL medications and ANY allergies you have.

FUNDUS PICTURE FORM

Make sure to fully read this paper. Check YES or NO and sign.

HIPPA FORM

Print date, Patient name and sign signature of responsible adult. This is the most important paper.

GENERAL MEDICAL RECORDS RELEASE FORM

Fill out the top section (Patient Name, Address, Phone, Last four SSN).

Please print the name of the custodian of your medical records (the name of the doctor's office that has your records).

Sign at the bottom.

Elliott Keller, O.D.

Name _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Home Phone _____

Email _____

Emergency Contact _____ Phone _____

Please check: Single _____ Married _____ Widowed _____ Divorced _____

Work Place _____ Work Phone _____

Work Address _____

Insurance Information

Medicare # _____ Medicaid # _____

Medical Insurance _____ Policy # _____

Vision Insurance _____ Policy # _____

Insurance Authorization

I hereby authorize Dr. Keller to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign the physician all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amounts not covered by insurance.

Signature of Responsible Party _____ Date _____

North Spartanburg Eye Center participates in the Spartanburg County Solicitor's Office Worthless Check Program and the charge for any returned checks will be \$30.00.

Health History

Patient Name _____ DATE _____

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease –Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	Head or Spinal injuries _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Convulsions, or Fainting _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery-Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	(Women)Are you pregnant or nursing _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Aids _____ # or yrs. _____
<input type="checkbox"/>	<input type="checkbox"/>	Any Nervous Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Extensive Confinement from illness or injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease – Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Do You smoke? ___#Packs Per Day__Week__Month__
<input type="checkbox"/>	<input type="checkbox"/>	Scarring Keloids _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you Drink? ___#Per Day__Week__Month__
Your Medical Doctor _____			<input type="checkbox"/>	<input type="checkbox"/>	Do You Live Alone? _____

Please List All Medications You Are Currently Taking:

Please List All Medications You Are Allergic To:

Your Ocular History (Have you been diagnosed with any of the following in the past?)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes _____	<input type="checkbox"/>	<input type="checkbox"/>	Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Iritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Disorders: _____

Cataract Surgery (Date of Surgery) Right _____ Left _____

Do you have a lens implant? Yes No

Other Eye Surgery & Date of Surgery: Right _____ Left _____

Explanation of Eye Injury: _____

Family History (Has anyone in your family (blood relative) has any of the following?)

**NOTE RELATION TO PATIENT: (F-Father M-Mother P-Paternal M-Maternal S-Sister B-Brother
GF-Grandfather GM-Grandmother U-Uncle A-Aunt)**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment _____
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Corneal Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinitis pigmentosa _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy _____	<input type="checkbox"/>	<input type="checkbox"/>	Other General Health Problems _____

Surgical History (Please include Date and Type – May be Continued on Back of Sheet)

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Dr. Elliott Keller

Welcome To The 21st Century

Dear Patient,

A new highly sophisticated computerized instrument now allows us to provide a more thorough medical analysis of your eye. The digital imaging system takes images of the retina (the back of your eye). This procedure assist the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. The images will be stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.

The doctor **strongly recommends** that all patients have this procedure performed. It is especially important for people who have:

- Headaches
- See spots or flashes
- Family history of Diabetes, High Blood Pressure, Glaucoma, or Macular Degeneration
- High Cholesterol
- Reached the age of 40
- New patients

There is an **additional charge of \$25.00** for this procedure. Please check the appropriate box below and sign at the bottom. ****insurance does not cover this procedure****.

I do want the procedure performed

I do NOT want the procedure performed

With my signature, I authorize treatment by Dr. Keller and staff. I understand I am financially responsible for all charges of any services rendered, including, if applicable, the balance remaining after possible insurance benefits. I authorize the staff at North Spartanburg Eye Center to act on my behalf regarding services received in their office. I authorize the release of any medical information necessary to process my insurance claim. I assign and request that insurance payments be made directly to North Spartanburg Eye Center. I further acknowledge that I have read their Notice of Privacy Practices, been offered a copy and authorize the staff to communicate by mail or phone.

Signature

Date

Member



American Optometric
Association

Elliott Keller O.D.

HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of

_____ *Dr. Elliott Keller* _____ O.D.

Notice of Privacy Practices. Date _____

Patient Name _____

Signature _____

**General Medical Records Release and
Authorization for Use of Disclosure of Protected Health Information**

Patient Name: _____

Address: _____

Phone: _____

Last four SSN: _____

I authorize the custodian of records of (provider/entity) _____

Address: _____

Phone/Fax: _____

To disclose/release the following information (check all applicable):

- | | |
|--|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Office notes (previous 2 years) | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> Laboratory/Pathology records (previous 3 years) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Radiology records (previous 3 years) | |

Please send records listed above to:

Name: Dr. Elliott Keller	Name _____
Address: North Spartanburg Eye Center	Address _____
8674 Asheville Highway	_____
Boiling Springs, SC 29316	Phone _____
Phone: 864-804-6412	Fax _____
Fax: 864-804-6413	

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment receive payment or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

Signature of patient (or patient's personal representative) Date _____

Printed name of patient representative Representative's authority to sign for patient