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	
☐	☐	Lung Disease –Type:_____	☐	☐	Head or Spinal injuries_____
☐	☐	Kidney Disease_____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Arthritis _____	☐	☐	Temporal Arteritis_____
☐	☐	Diabetes _____	☐	☐	Carotid Artery-Disease _____
☐	☐	Neurological Disease_____	☐	☐	(Women)Are you pregnant or nursing _____
☐	☐	Migraines_____	☐	☐	Stroke _____
☐	☐	Psychiatric Disorder _____	☐	☐	HIV/Aids _____# or yrs._____
☐	☐	Any Nervous Disorder_____	☐	☐	Extensive Confinement from illness or injury _____
☐	☐	Heart Disease _____	☐	☐	Permanent defect from illness, disease or injury_____
☐	☐	Gastrointestinal disease – Type:_____	☐	☐	Suffering from any other Disease _____
☐	☐	High Blood Pressure _____	☐	☐	Do You smoke?___#Packs Per Day__Week__Month__
☐	☐	Scarring Keloids _____	☐	☐	Do you Drink? _____#Per Day___Week___Month___
Your Medical Doctor _____			☐	☐	Do You Live Alone? _____

Please List All Medications You Are Currently Taking:

_____

_____

_____

_____

Please List All Medications You Are Allergic To:

_____

_____

_____

_____

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

Yes	No		Yes	No	
☐	☐	Cataracts_____	☐	☐	Corneal Disease _____
☐	☐	Retinal Disease _____	☐	☐	Glaucoma _____
☐	☐	Crossed Eyes _____	☐	☐	Injury _____
☐	☐	Iritis_____	☐	☐	Other Eye Disorders:_____

Cataract Surgery (Date of Surgery) Right _____ Left _____

Do you have a lens implant? Yes ☐ No ☐

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

Explanation of Eye Injury: _____

<u>Family History</u> (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	
☐	☐	Glaucoma_____	☐	☐	Retinal Detachment _____
☐	☐	Cataracts_____	☐	☐	Other Eye Problems _____
☐	☐	Corneal Disease_____	☐	☐	Diabetes _____
☐	☐	Macular Degeneration _____	☐	☐	Heart Conditions _____
☐	☐	Retinitis pigmentosa _____	☐	☐	Stroke _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Other General Health Problems _____

<u>Surgical History</u> (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):

__All records
__Office notes (previous 2 years)
__Laboratory/Pathology records (previous 3 years)
__Radiology records (previous 3 years)
__ Billing Records
__ Pharmacy/prescription records
__ Other

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.

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

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