Wildwood Vision Specialists

Patient Information

Kim Folwarski Brown O.D.

Christy Hayes O.D.

Date: ________________

Patient Information:

Legal Name: ______________________________
Preferred Prefix: Dr. / Mr. / Mrs. / Ms. / Miss
Nickname(if any):____________________________
Address:___________________________________
City: ______________ State: ______ Zip: ________
Cell Phone: _______________________________
Email Address: ____________________________
Marital Status: Single / Married / Divorced / Widowed
Race: ______________ Alt. Race: __________
Ethnicity: Hispanic/latino **OR** nonhispanic/latino

MALE / FEMALE
Date of Birth: _______________
Last 4 of Social: ____________
Employer/School: ____________
Home Phone: ______________
Work Phone: ___________________________
Communication Preference: (circle one)
Email / Phone / Mail / Text

Preferred Language: ____________________

Guarantor/Insurer Information:

Name of Guarantor: _______________________
Date of Birth of Guarantor:___________________
Last 4 of social of Guarantor: ________________
Guarantor Employer:________________________

Phone number of Guarantor:________________
Address of Guarantor if different from above:
____
City: ____________ State: ______ Zip:_______

Medical History:

Primary Reason for Visit:	Other Reason for Visit:

Do you wear glasses? Yes / No **Do you wear contacts?** Yes / No **Are you interested in contacts?** Yes / No
Are you interested in Lasik? Yes / No

Date of last eye exam: _______________________

Last Eye Doctor: _________________________

MEDICATIONS
List any medications which you are currently taking.

____
____
____
____
____
____
____

ALLERGIES
List all allergies to medications and medical substances.

____
____
____
____
____
____

Vitals: Height: ______ft _____ in.

Weight: ___________ lbs.

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Medical History Information:

Past History:

Ocular:

Check Which Apply: ___ None apply

____ Glaucoma
____ Cataracts
____ Age-related Macular Degeneration
____ Diabetes Retinopathy
____ Carcinoma
____ Surgery:______________________________
____ Crossed/Lazy Eye
____ Other: ______________________________

Medical:

Check Which Apply: ___ None apply

____ Hypertension
____ Diabetes Mellitus
____ Cholesterol
____ Heart Disease
____ Other:______________________________
____ Other: ______________________________

Family History:

Ocular: ___ None apply

Check Which Apply and List Relation:

____ Glaucoma ______________________________
____ Cataracts______________________________
____ Age-related Macular Degeneration _______
____
____ Other: ______________________________

Medical: ___ None apply

Check Which Apply and List relation:

____ Hypertension ______________________
____ Diabetes Mellitus ____________________
____ Other:______________________________
____ Other: ______________________________

Social History:

- ☐ Recreational Drug Use Yes / No Type: _________

Tobacco use: Type: Smoke / Smokeless

___ Never Smoker
___ Former smoker: Yes/ No
Date last used: ________
____Current smoker: Yes/ No
If yes: Daily / Socially / Occasionally

- ☐ Alcohol consumption frequency:____________

Do you use a computer/Digital Device: Yes / No
Hours spent on digital device? _____________
Hobbies: ______________________________
____

I certify that the information given by me in applying and/or insurance payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Wildwood Vision Specialists on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents as any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above.

Patient Signature_______________________________________ Date:______________________

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Review of Systems Information:

System	NO	YES	Year of Diagnosis	Explain/Medications	System	NO	YES	Year of Diagnosis	Explain/ Medications
Hematologic/Lymphatic					**NEUROLOGICAL**				
Anema					Multiple sclerosis				
Large Volume Blood Loss					Epilepsy				
Leukemia					Alzheimers				
RESPIRATORY					Parkinsons				
Asthma					Cerebrovascular				
Bronchitis					**ENDOCRINE**				
Emphysema					Non-insulin				
GENITOURINARY					Insulin-dependent				
STD, viral herpetic, chlamydia					Thyroid dysfunction				
Other:					Hormonal				
PSYCHIATRIC					**INTEGUMENTARY**				
Depression					Eczema				
Panic disorder					Rosacea				
Schizophrenia					Psoriasis				
EARS, NOSE, MOUTH,					**CONSTITUTIONAL**				
Upper Resp. Tract Infection					Developmental				
Ear Ache					Weight Loss				
Runny Nose					Fever				
Sore Throat					Fatigue				
Ringing/Tinitis					Trauma				
MUSCULOSKELETAL					**ALLERGIC/**				
Fibromyalgia					Drug allergy				
Musclar dystrophy					Environmental allergy				
Osteoarthritis					Rheumatoid arthritis				
Ankylosing spondylitis					Lupus				
CARDIOVASCULAR					**EYES**				
Heart disease					Glaucoma				
Hypertension					Cataract				
Stroke					AMD				
Vascular disease					Surgery				
GASTROINTESTINAL					Inflamatory disorders				
Crohn's					Blurred vision				
Colitis					Double vision				
Ulcer					**ARE YOU CURRENTLY PREGNANT?**			**HOW MANY WEEKS?**	
Digestive					**ARE YOU CURRENTLY NURSING**				
***** HISTORY OF MAJOR ILLNESSES**					***** HISTORY OF MAJOR SURGERIES AND/OR HOSPITALIZATION**				

p: 636.273.3910 2751 Fountain Place Suite 2 Wildwood, Missouri 63040-1202 f: 636.293.3918

Wildwood Vision Specialists

Acknowledgment of Receipt of Notice of Privacy Practices

I, ___________________________________ have received a copy of this office's updated Notice of Privacy Practices.
Print patients name

I would like the following persons to have access to my PHI upon their request:
(No one other than the patient will be allowed access to the patients PHI unless they are listed below)
Please include name and relationship to patient

____
____
____
____
____

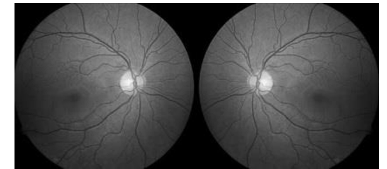
____
Signature of patient/legally guardian/legally responsible person

____
Date

____
Description of relationship to the patient

For Office Use Only:
We attempted to obtain written acknowledgment of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual/Representative refused to sign the form
An emergency situation prevented us from obtaining acknowledgment
Other:____
____

WVS offers options for the health examination of your eyes



Digital Wellness Check: WVS offers the latest technology in their eye examinations including a digital wellness examination which will allow the doctor to document the health of the back of your eyes (retina, macula, optic nerve and blood vessels). This is recommended for <u>all patients</u> but especially for those with **family history of macular degeneration or glaucoma, high blood pressure, heart disease, diabetes or high cholesterol**. There is an extra $40 charge that is NOT covered by insurance.

I would like to: ☐Have a digital wellness check today ☐Not have a digital wellness check today

Dilation: WVS recommends dilation of the eyes to see a comprehensive view of the back of the eye, this allows the doctors to see the whole back of the eye, checking for diseases such as diabetes, hypertension, retinal detachments, among many others. Dilation is performed with dilating drops, and side effects such as blurry near vision and light sensitivity will last about 4 hours. Dilation is covered as part of your comprehensive eye exam.

I would like to: ☐Have dilation today or reschedule for another time ($25 fee for 2nd visit)
☐Decline dilation ☐Talk to my doctor about this option