PATIENT INFORMATION:

Full Name: _____Date of Birth: _____ M / F

Nickname: _____SS#: _____

Street Address: _____City:_____ State: _____

Zip Code: _____Home Phone: _____ Daytime Phone: _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____Preferred Language: _____

Marital Status: M_____D_____S_____SEP_____W_____ Do you wear glasses or contacts now? GLS ( ) CLS ( ) NO RX ( )

Employment Status: FT_____PT_____UNEMPLOYED_____ Employer: _____ Occupation: _____

ETHNICITY: RACE:

Native Hawaiian/Other Pacific Islander ( ) American Indian/Alaska Native ( ) Asian ( )

Hispanic/Latino ( ) Caucasian ( ) African American/Black ( )

Not Hispanic/ Latino ( )

PLEASE COMPLETE THE INSURANCE INFORMATION BELOW

Medical Insurance:_____ Vision Insurance: _____

Primary Insured's Full Name: _____ Primary Date of Birth: _____

Primary's Place of Employment: _____ Occupation: _____

Social Security Number of Primary: _____

Dilation Information and Consent

A dilated pupil exam is a highly recommended part of your comprehensive eye examination. It allows the doctor to better examine the retina (the inside of your eye). Dilation is strongly recommended for the following patients:
1) Those who are over 40 years of age; 2) Those who have high prescriptions. 3) Those diagnosed with diabetes, high blood pressure, heart disease or any other systemic health conditions. **This will last between 4-6 hours.**

( ) Yes I consent to be Dilated ( ) No, I do not want to be Dilated.

RETINAMAP

This advanced technology is highly recommended and used to detect early signs of retinal disorders, including but not limited to; glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. It is fast and painless. It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the **RETINAMAP** images can be viewed side by side to discover subtle changes and monitor your continuing eye health. It does not take the place of dilation, but in most cases, dilation will not be necessary with pictures. This is **NOT COVERED** by insurance plans unless we are actively following pathology.
There is a fee of $35.00 associated with the testing.

DO YOU WISH TO HAVE THE RETINAMAP TEST YES ( ) NO ( )

PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No		Yes	No
Cataract	▪	▪	Women- Are you pregnant?	▪	▪
Eye Turn	▪	▪	Are you breast feeding?	▪	▪
Glaucoma	▪	▪			
Macular Degeneration	▪	▪	Have you ever had a blood transfusion?	▪	▪
Retinal Detachment	▪	▪			

	Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Blindness	▪	▪	_____
Eye Turn	▪	▪	_____
Glaucoma	▪	▪	_____
Macular Degeneration	▪	▪	_____
Retinal Detachment	▪	▪	_____

Other: _____

Review of Systems: Please indicate below if you have any problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other: _____

Gastrointestinal
- None
- Colitis
- Acid Reflux/Ulcer
- Other: _____

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Cholesterol

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Crohn's Disease
- Other: _____

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other: _____

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other: _____

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other: _____

Hematologic/Lymphatic
- None
- Anemia
- Multiple Sclerosis
- Leukemia
- Bleeding Disorder
- Other: _____

Neurological
- None
- Weight loss/gain
- Epilepsy
- Tremors
- Other: _____

General Health
- None
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use: Current Smoker ( ) Former Smoker ( )
  Smoked a day_____ How many years quit_____
- Non-Prescription Drugs_____
- Alcohol Consumption_____
- Weight_____ Height_____

Please sign below to acknowledge that this form is current:

FINANCIAL POLICY

For Patients WITH or WITHOUT Vision Insurance Coverage:

WITH COVERAGE:** We cannot bill your insurance company unless you give us ***your most recent insurance information ***at the time of your visit.*** If you have managed care plan, a co-payment is due at the time of your visit, and must be paid at that time. Payment for any non-covered services is due at the time of your visit. **OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.**

I understand my obligation to pay any amount not covered by third parties and further agree to pay any amount remaining unpaid by such third parties ninety days after the date of service.

Initials of Responsible Party: _____

WITHOUT COVERAGE:** Since you have ***NO vision insurance coverage, payment in full for your services is due at the time of your visit.

Initials of Responsible Party: _____

Eyeglass / Contact Lens Customer Agreement

I _____ understand that it is my responsibility to report any and all problems with eyeglasses/contact lenses within 30 days of my exam to Shannon EyeCare. Failure to do so will result in loss of warranty and may result in additional fees. Please help us to help you by letting us know as soon as you realize you have a problem. I understand that contact lenses are classified as an FDA controlled medical device that must be evaluated and fit to my unique eye each year, even if you are already a contact lens wearer. Contact lens prescriptions are only valid for 12 months. This is considered a separate medical procedure, therefore, any and all fees for contact lens fitting and evaluations are not included in your routine eye exam.

_____

Signature of patient / legal guardian *Relationship to patient* *Date*

Consent to Treat Minor- Please Fill Out if Patient is Under 18 Years of Age:

I give my permission to Dr. Michael Shannon and/or Dr. Michael Roberts to treat my son/daughter without my presence. I understand that I am responsible for providing any necessary information regarding insurance coverage and I accept responsibility for any services and fees rendered that are not covered by my insurance.

Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): _____ Date: _____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign this form): _____

Relationship of Patient Representative to Patient: _____

SHANNON EYE CARE
& OPTIQUÉ

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
MEDICAL RECORD RELEASE

AT MY REQUEST, I AUTHORIZE:

Shannon Eyecare, P.C. (Dr. Michael Shannon and/or Dr. Michael Roberts)

5900 Spout Springs Rd, Suite I-9
Flowery Branch GA. 30542
P:770.965.2401/F:770.965.2546

210 Hudson St.
Cumming, Ga. 30040
P:770.887.9171/F:770.887.9180

TO DISCLOSE THE FOLLOWING INFORMATION: (description of individual health information to be disclosed)

- Any and all of the medical records pertaining to the treatment of the individual
- Other (specify): _____.

PURPOSE OF DISCLOSURE: At the request of the individual/legal guardian:

I understand that any disclosure of health information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal privacy rules.

I understand that I have the right to revoke this Authorization at any time, except to the extent action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides any insurer with the right to contest a claim under my policy. (The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to receive the information, the signature of the person with legal authority for authorization/revocation, and their phone number.)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits.
Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below.

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ _____
Signature of patient / legal guardian *Relationship to patient* *Date*