AGAPE EYE CARE

Name:_____ Gender: M☐ F☐

Address: _____City_____State_____Zip_____

Phone: (H)_____(W) _____ (C) _____

Date of Birth:____/___/_____ Marital Status:☐Single☐Married☐Divorced☐Widow

SSN: ___/___/_____ Ethnicity: ☐Hispanic/Latino☐Non-Hispanic or Latino

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Preferred Language:☐English ☐Spanish ☐Italian ☐French ☐Chinese
☐Russian ☐Other _____

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander ☐White ☐Other _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

Referred by:_____
Address:_____

Primary Care Physician:_____
Address:_____

Employer:_____
Address: _____
Is this a No-Fault Claim☐Yes ☐No Is this a Work Related injury?☐Yes ☐No
Are you covered by Insurance?☐Yes ☐No

Medical Insurance:_____ID:_____

Group ID#:_____Policy Holder:_____

Policy Holder DOB: ___/___/_____ SSN:_____/___/_____

Vision Insurance:_____ID:_____

Group ID#:_____Policy Holder:_____

Policy Holder DOB: ___/___/_____SSN:_____/___/_____

Email Address: _____

Patient Authorization

I authorize payment of medical benefits to the above stated physician for services rendered. I acknowledge that I am financially responsible for all charges whether or not covered by insurance. I also authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

_____ _____

Signature of Patient or Legal Guardian **Date**

AGAPE EYE CARE

NAME: _____ **DATE OF BIRTH:** _____

Please read the following information and fill in appropriate answers.

Describe the eye problem that brings you here: _____

_____

Ocular (Eye) History (please check all that apply to your past and present history and circle which eye)

	Yes	No	
Cataracts	☐	☐	Right Left
Macular Degeneration	☐	☐	Right Left
Glaucoma	☐	☐	Right Left
Diabetic Retinopathy	☐	☐	Right Left
Retinal Detachment/Tear	☐	☐	Right Left
Amblyopia (lazy eye)	☐	☐	Right Left
Eye Injury	☐	☐	Right Left
Myopia (Nearsighted)	☐	☐	Right Left
Other: _____	☐	☐	Right Left

Ocular (Eye) Procedural History (please check all that apply and circle which eye)

	Yes	No	
Cataract Surgery	☐	☐	Right Left
Glaucoma Procedure	☐	☐	Right Left
Retinal Tear Laser	☐	☐	Right Left
Retinal Detachment Procedure:	☐	☐	Right Left
(if yes, please list type: (_____)			
Diabetic Retinopathy Laser	☐	☐	Right Left
Eye Injections	☐	☐	Right Left
Type: _____			
Other: _____	☐	☐	Right Left

Have you had any other eye problems in the past not listed? If so, please list dates and specify which eye: _____

_____

_____

Have you had any surgeries that do not involve the eye? If so, please list what the surgery was and the date it was performed: _____

_____

_____

_____

_____

Do you use:

Tobacco?	☐ Yes	☐ No	If yes, how often? _____
Alcohol?	☐ Yes	☐ No	If yes, how often? _____
Eye glasses?	☐ Yes	☐ No	
Contact Lenses?	☐ Yes	☐ No	

Are you allergic to any medications? If so, please list the medication and the reaction you experience: _____

_____

_____

_____

Family History (If you have relatives that have had any of the following problems listed, please circle and list which family member)

Diabetes _____ Macular Degeneration _____

High Blood Pressure _____ Glaucoma _____

Cancer _____ Retinal Detachment/Tear _____

Heart Disease _____ Early Blindness _____

Stroke _____ Other: _____

AGAPE EYE CARE

NAME: _____ **DATE OF BIRTH:** _____

Please list all current medications. Be sure to include **prescriptions, blood thinners, eye drops, and non-prescription** (i.e. herbal supplements, over the counter medications, and vitamins).

MEDICATION	DOSAGE	HOW OFTEN

FOR OFFICE USE ONLY

_____ _____

Reviewed by **Date**

AGAPE EYE CARE

Acknowledgement of Receipt of Privacy Policy

I understand that Agape Eye Care Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of the health care operations of Agape Eye Care Our Notice of Privacy Practices explains our use and disclosure of your Protected Health Information. This notice is posted in the office reception area. I acknowledge that I can receive a copy of this notice.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Agape Eye Care has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

Disclosures

Do we have permission to:

Leave Appointment Information:		**Leave Medical Information:**	
On Home Phone?	☐	On Home Phone?	☐
On Cell Phone?	☐	On Cell Phone?	☐
On Office Voicemail?	☐	On Office Voicemail?	☐
With Another Person?	☐	With Another Person?	☐
Via Mail?	☐	Via Mail?	☐

Person(s) Authorized to Communicate With:

Name _____ Address _____ Relationship _____

Phone (H) _____ (W) _____ (C) _____

Name _____ Address _____ Relationship _____

Phone (H) _____ (W) _____ (C) _____

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Patient Name (Print) _____ Date of Birth _____

Name of Legal Guardian (Print) _____ Relationship to Patient _____

Signature of Patient or Legal Guardian _____ Date _____

AGAPE EYE CARE

NAME: _____ **DATE OF BIRTH:** _____

Please read and review the following information. If you currently have or have ever had any of the problems listed below, please circle and sign the line at the bottom of page.

Cardiovascular
- ~~High Blood Pressure~~ ☐
- High Cholesterol ☐
- Heart Attack ☐
- Stroke ☐
- Congestive Heart Failure
- Other: _____

Endocrinologic
- Diabetes ☐
- Underactive Thyroid ☐
- Overactive Thyroid ☐
- Grave's Disease ☐
- Thyroid Cancer ☐
- Other: _____

Neurological
- Migraines ☐
- Neuropathy ☐
- Numbness/Tingling ☐
- Spinal Stenosis ☐
- Parkinson's ☐
- Alzheimer's ☐
- Seizures ☐
- Other: _____

Respiratory
- Asthma
- COPD ☐
- Emphysema ☐
- Shortness of breath ☐
- Lung Cancer ☐
- Sleep Apnea ☐
- Chronic Bronchitis ☐
- Other: _____

Musculoskeletal
- Arthritis ☐
- Osteoporosis ☐
- Degenerative Disc Disease ☐
- Gout ☐
- Ankylosing Spondylitis ☐
- Scoliosis ☐
- Other: _____

Skin
- Eczema ☐
- Psoriasis ☐
- Skin Cancer ☐
- Rash ☐
- Other: _____

Genitourinary
- Prostate Cancer ☐
- Bladder Problems ☐
- Kidney Problems ☐
- Ovarian Cancer ☐
- Other: _____

Gastrointestinal
- ~~Irritable Bowel Syndrome~~ ☐
- GERD/Reflux ☐
- Constipation/Diarrhea ☐
- Stomach Cancer ☐
- Colon Cancer ☐
- Pancreatitis ☐
- Crohn's Disease ☐
- Other: _____

Hematologic/Lymphatic
- Anemia ☐
- Blood Disease: _____
- Leukemia ☐
- Sickle Cell Anemia ☐
- Lymphoma ☐
- Other: _____

Allergies/Immunologic
- Seasonal Allergies ☐
- Rheumatoid Arthritis ☐
- Systemic Lupus Erythematosus ☐
- Sarcoidosis ☐
- Multiple Sclerosis ☐
- Myasthenia Gravis ☐
- Sjogren's Syndrome ☐
- Scleroderma ☐
- Other: _____

Ears/Nose/Throat
- Chronic Sinusitis ☐
- Hearing loss ☐
- Tonsilitis ☐
- Nose bleeds ☐
- Throat Cancer ☐
- Tinnitus ☐
- Ear infection ☐
- Other: _____

Mental Health
- Anxiety ☐
- Depression ☐
- Bipolar Disorder ☐
- Panic Disorder ☐
- Dementia ☐
- Post Traumatic Stress Disorder ☐
- Eating Disorder ☐
- Other: _____

_____ _____

Patient Signature **Date**

AGAPE EYE CARE

COME SEE THE DIFFERENCE

This practice adheres to the annual review of ultra-wide field imaging for every comprehensive exam with an Optomap retinal screening.

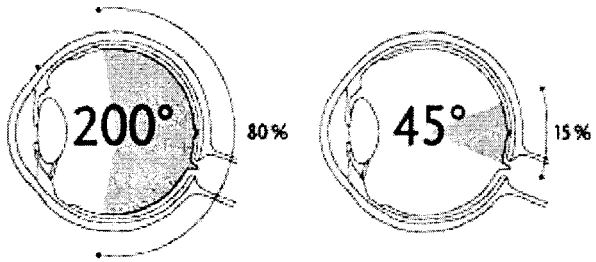
The Optomap discovers many important health conditions that would have been missed without following this procedure. Detecting these conditions at the earliest possible stage is the best way to preserve sight and overall health of the eye.

This screening procedure can also detect problems unrelated to the eye that may produce early warning signs in the eye such as hypertension, cancer, and auto-immune disorders, tumors, and others.

The fee for this procedure is $45.00.

This procedure…

- Is as fast as taking a picture.
- **DOES NOT REQUIRE DILATING DROPS, thus possibly eliminating a 30 minute dilation** time in the waiting room, and avoids blurry near-vision and light sensitivity for 2 hours after your eye exam.
    - In certain circumstances, Dr. Crowe may still need to dilate.



with optomap ultra-widefield retinal imaging

without optomap

☐ I elect to get the Optomap performed

☐ I want to speak to the doctor for more information and understand that declining this procedure may limit the doctor's ability to optimally assess my ocular health

Signature: _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting you medical care to Agape Eye Care. When you schedule an appointment with Agape Eye Care we set aside enough time to provide you with the highest care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us enough time schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1st,2018 any patient who fail to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a **$25.00** fee.
- Any patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee.**
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Agape Eye Care.
- As courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your schedule appointment. If you should experience extenuating circumstances please contacts our office, in which we may be able to waive the No Show fee. You may contact Agape Eye Care Mon 9-7, Tues 9-5, Wed 9-7, Fri 9-5, and Sat 9-1. If no one answers or you call after business hours you may leave a message.

Agape Eye Care **(518) 899-0003**

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date