HISTORY – PLEASE COMPLETE ALL OF THIS FORM - Name(s) of Insurance _____

Social Security #_____ Exam Date_____

Name_____

Address_____City_____State_____Zip_____

Phone_____ Cell_____ Work_____

Email_____

Date of Birth_____ _____/_____/_____ Age_____

Height____ft ____inches Weight in lbs._____ Blood Pressure _____/_____ (example) 120/80

Race: African American Caucasian Native American Asian European Hispanic Arab Indian Pacific Islander

Ethnicity _____ Language_____

Referred to us by_____Primary Care Physician_____

Eye Doctor _____Date of last eye exam_____

Reason for today's visit_____

Patient Medical Eye History: Circle all those that apply to **you (the patient)**:

Cataract Surgery Cone Dystrophy Crossed Eyes Diabetic Retinopathy Double Vision

Drooping Lid (Ptosis) Dry Eye Eye Injury Glaucoma Lasik Lazy Eye (Amblyopia)

Loss of Side Vision Macular Degeneration Nystagmus Ocular Albinism Optic Atrophy

Retinitis Pigmentosa Retinal Detachment Stargardt's Traumatic Brain Injury _____

Other Eye Condition (not listed) _____

Family History – List blood relatives who have had the following conditions:

Cataracts _____ Macular Degeneration _____

Diabetic Retinopathy _____Retinal Detachment _____

Glaucoma _____ Other _____

Do you use a hand held magnifying glass? Daily Occasionally Never No longer helps

Do you use a tablet (Kindle, I-Pad, etc) to read? No Yes

PLEASE BE SURE TO COMPLETE THE OTHER SIDE >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

Do you drive a motor vehicle? No Yes On a regular basis_____ Daytime Only _____

Difficulty seeing while driving? No Yes Street Signs_____ Traffic Lights_____

Social History

Do you use tobacco? No Yes Type of product _____

If YES, for how long have you used tobacco _____years - Quit tobacco use in (year quit, ie 1999) _____

Do you consume alcohol? No Yes Type/Frequency _____

Do you use illegal drugs? No Yes (If applicable): Are you pregnant or nursing? No Yes

History/exposure to: HIV/AIDS_____ Hepatitis_____ Gonorrhea_____ Syphilis_____ None_____

REVIEW OF SYSTEMS

Please ***CIRCLE*** only those that apply:

Eyes: Difficulty recognizing: faces news print distortion loss of side vision itching
light sensitivity eye pain styes flashes floaters certified legally blind

Skin: rash _____

Bones/ Joints/ Muscles: Arthritis

Endocrine: Diabetes No Yes For how long have you been treated for diabetes? _____years _____months

Head: Headaches No Yes For how long have you had headaches? _____ years _____months

Ears/Nose/Throat: Allergies Sinus Infections

Vascular/ Cardiovascular: High Blood Pressure Stroke TIA (mini-stroke)

Nervous System: frequent falls difficulty walking seizures

Do you wear Eye Glasses No Yes - Used for: Distance Near (Reading) Both

How old are your glasses? _____ years old - **Do you have a prescription you have not yet filled?** No Yes

CURRENTLY wearing Contact Lenses? No Yes - Soft Hard/Gas Permeable Mono-vision Bifocal

Right Lens Power _____ Left Lens Power _____

I **REMOVE** my contacts Every Evening_____ Once a Week_____ Once a Month_____ other _____

I **REPLACE** my contacts Daily Weekly Monthly Other:_____

Patient's Signature _____

ACKNOWLEDGEMENT OF

NOTICE OF PRIVACY PRACTICES

The law requires that Brian M Celico OD PA make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that: ***(Please circle a box)***

I have read or had explained to me prior to any services offered Brian M Celico OD PA's Notice of Privacy Practice and agree to continue my care with Brian M Celico OD PA under said terms.

I was given to opportunity to read Brian M Celico OD PA's Notice of Privacy Practices and declined but wish to continue my care with Brian M Celico OD PA under the terms of Brian M Celico OD PA's privacy policies.

I have read or had explained to me prior to any services offered Brian M Celico OD PA's Notice of Privacy Practice and do not wish to continue my care with Brian M Celico OD PA under said terms.

The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as :_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

AUTHORIZATION FOR RELEASE OF
IDENTIFYING HEALTH INFORMATION

Brian M Celico OD PA

Dr. Brian Celico, Privacy Official

Patient Name _____

Patient Address _____

Patient Phone Number_____

I authorize Brian M Celico OD PA to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, genetic information, and HIV infection or AIDS) under the following conditions:

- Specific information to be released:_____
- Reason for the release:_____
- Name and address of recipient:_____
- Termination date for authorization:_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare 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 request that payment of these benefits be made either to me or on my behalf to Brian M. Celico, OD, PA 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 and information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-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.

Sign Here _____

Date _____

TURN OVER, NEXT PAGE

Brian M. Celico, OD
Low Vision Specialist
4100 W. 15th Street – Suite 206 Plano, Texas 75093
Office: 214-265-1111 Fax 214-265-1189

Pharmacy Name: _____ Phone Number: _____

Medication List

List ALL medications you are currently taking, including: Prescription medication, over-the-counter medications, eye medication, and herbal remedies.

List your Eye Medication(s)	List Oral Medication(s) (Pills)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies

List any and ALL medications you are allergic to and the TYPE of reaction you have to each

_____
_____
_____
_____
_____

O Check if you have no known allergies to medications.

Patient Name: _____

Patient's Signature: _____

Date: _____