DR. MCGREGOR &ASSOCIATES

Dr. Brent Collins- Dr. Randall Baughman

WELCOME TO OUR OFFICE!

Name: _____ Today's Date:_____

Address: _____ City: _____ State: ____ Zip: _____

Sex: M ____ F____ SS#: _____ -_____-_____ Date of Birth: _____

Home #: (____) _____Work #: (____) _____Cell:(____) _____

Email Address: _____ How often do you check your email? _____

Emergency Contact Name & #: _____ Relationship to Patient: _____

Family Physician Name & #: _____ Employer: _____

Insurance: If **ANY** Insurance Coverage, Please **Complete In Full**:

Insurance Name:_____ ID#: _____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

Referral Source: How did you here about us? (Please Check)

Friend /Relative Name:_____ Dr. _____ Website

Office Sign Yellow Pages Newspaper Radio Vision Screening Direct Mail

Insurance Do you have any other relatives that are patients? Name(s)_____

Review of Symptoms

Weight Loss	**Y**	**N**
Fever	**Y**	**N**
Fatigue	**Y**	**N**
HIV	**Y**	**N**
Decreased Hearing	**Y**	**N**
Loss of Smell	**Y**	**N**
Throat	**Y**	**N**
Eye Disease	**Y**	**N**
MRSA Infection	**Y**	**N**
Palpitations	**Y**	**N**
Chest Pain	**Y**	**N**
Blood Pressure	**Y**	**N**
Wheezing	**Y**	**N**
Shortness Of Breath	**Y**	**N**
Cough	**Y**	**N**
Seizures	**Y**	**N**
Fainting	**Y**	**N**
Headaches	**Y**	**N**
Blood Sugar	**Y**	**N**
Blood Clotting	**Y**	**N**
Anemia	**Y**	**N**
Joint Pain/Swelling	**Y**	**N**
Arthritis	**Y**	**N**
Blood in Urine	**Y**	**N**
Urinary Infections	**Y**	**N**
Thyroid	**Y**	**N**
Ulcers	**Y**	**N**
Gastro Bleeding	**Y**	**N**

Other _____

Medications

Please list ***ALL*** the prescription and non- prescription medication you are taking

_____

_____

Medical History

Are you allergic to any medications? **YES OR NO**

Please list if any:_____

Are you Pregnant? **YES OR NO** Are you under the care of a physician? **YES OR NO**

Please list any Health Conditions: _____

_____

Physician treating you: _____ Last Physical: _____

Family History

Cataract	**Y**	**N**	Relationship: _____
High Blood Pressure	**Y**	**N**	Relationship: _____
Retinal Detachment	**Y**	**N**	Relationship: _____
Blindness	**Y**	**N**	Relationship: _____
Thyroid	**Y**	**N**	Relationship: _____
Heart Disease	**Y**	**N**	Relationship: _____
Glaucoma	**Y**	**N**	Relationship: _____
Diabetes	**Y**	**N**	Relationship: _____
Macular Degeneration	**Y**	**N**	Relationship: _____

Other: _____

Have you had any of the following eye problems?
Circle all that apply:

Burning	Dryness
Sensitivity to light	Sudden Loss of Vision
Eye Surgery	Eye Strain
Cloudy Vision	Recurring Infection
Blurry near vision	Itching
Flashes of Light	Soreness
Redness	Watery Eyes
Gritty feeling in your eyes	Double Vision
Objects floating in your vision	Seeing at night
Eye Injury	
Seeing in the distance	
Halo's around lights	

Comments:

Social History

Do you work at a computer for long periods?	YES NO
Do you have more than one pair of current prescription glasses?	YES NO
If you wear glasses, are you interested in thinner lighter lenses?	YES NO
Do you wear bifocals?	YES NO
If so are you bothered by head tilting, restricted areas of vision correction, etc.?	YES NO
Do you drink alcohol ?	YES NO
Do you Smoke?	YES NO
How Much?	_____
Do you spend a lot of time outdoors?	YES NO
Do you have sunglasses filtering 100% of UV rays?	YES NO
Are you bothered by glare or reflection particularly while driving at night?	YES NO
Are you interested in contact lenses?	YES NO

Hobbies and Special Interest: _____

List any problems or areas of concern or interest you would like the doctor to address today?
_____

FINANCIAL INFORMATION
PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED

Person financially responsible for payment: _____ SSN# : _____

Method of payment: Cash _____ Check _____ Visa _____ MasterCard _____ Discover _____ American Express _____ Other _____

1. Dr. McGregor and Associates has permission to release any information concerning my condition and treatment to my insurance carrier, referring physician or doctor, including any doctors to whom I may be referred to by McGregor and Associates for this date and any future dates.
2. I will pay Dr. McGregor and Associates for all services at the time they are rendered, including any non- covered services or deductibles, regardless of insurance coverage (except Medicaid). There is a $25.00 service charge for all checks returned for ***ANY REASON,*** and I will be personally responsible for any and all cost of collection, including attorney's fee.
3. By signing below, I certify that all information provided on this form is true and correct, to the best of my knowledge and give Dr. McGregor and Associates permission to examine and treat me.
4. If assignment of insurance benefits is accepted, I authorize payment to be made to Dr. McGregor and Associates by my insurance company.

I authorize any holder of medical or other information about me to be releases to the Social Security Administration and Health Care Financing Administration or it' intermediaries or carriers. I permit a copy of this authorization to be used in place of the original and request payment of insurance benefits either to myself or to the party who accepts assignment. Payment is made based on regulations pertaining to Medicare assignment of benefits.
As a Medicare patient I understand that the services below are not covered by Medicare and I accept responsibility for payment of the full amount of the services, including but not limited to: Driver License Forms, Rose Bengal, Refraction's and After Hour and Weekend visits. I agree to provide Dr. McGregor and Associates a copy of my Medicare and Supplement insurance cards.

Patient Signature: _____ Date: _____

In keeping with our mission to provide the latest technology in caring for your eyesight, we offer two elective procedures-digital retinal imaging and laser glaucoma screening.

The **digital retinal camera** takes an image of the optic nerve and retina (the camera film at the back of the eye). The images are added to your medical records assisting your doctor in the early detection of glaucoma, diabetic retinopathy, macular degeneration, retinal tears or detachments, and other vision threatening conditions.

For most patients the doctor's view of the retina is limited by the small pupil size. We recommend digital retinal imaging should the dilation not be possible for you today. Both digital retinal imaging and dilation are helpful, though only dilation is medically necessary for routine eye exams and therefore included in the cost of the exam.

Laser glaucoma screening is done with the GDX-VCC, a laser that safely measures a portion of the retina known to be damaged in the early stages of glaucoma. This reading takes a couple of minutes, does not require dilation, and the results are immediately available. Allowing us to detect and begin treatment for glaucoma earlier reduces the chance of irreversible blindness.

The cost for each procedure is $19.00 or $38.00 for both. This is an additional, out of pocket expense, and is not covered by vision or medical insurance. Because of known risk factors we ***strongly recommend*** the tests for the following:

Both Procedures	**Digital Retinal Imaging**	**Laser Glaucoma Screening**
-family history of glaucoma	-headaches	-African Americans over 30
-family history of diabetes	-spots or flashes of light	-nearsightedness
-over the age of 40	-high cholesterol	-previous eye surgery or injury
	-family history of high blood pressure	
	-new patient	

_____I elect to have these $38.00 procedures _____I elect the $19.00 digital retinal imaging
_____I decline these additional services _____I elect the $19.00 Laser glaucoma screening

NOTICE OF YOUR PRIVACY RIGHTS AND PRACTICES

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our practice may use the following information in the following manners:

1. Treatment, payment or health operations which may include filing of insurance claims.
2. Appointment reminder calls to your home, work or cell numbers or voice mail you have provided.
3. Appointment reminder postcards by mail.
4. Notification by phone or mail of our practice's marketing or promotional offers.
5. Phone calls pertaining to contact lens or glasses orders to phone numbers you have provided.

A complete notice of our privacy practices is posted in each exam room as well as the receptionist area. If you have any questions, please feel free to contract the receptionist or your doctor. If you agree to allow our practice to use your health information in the methods above, please check the appropriate box and sign and date below. If you disagree, please place a check in the appropriate box and sign and date. Thank You!

I **allow** Dr. McGregor and Associates to use my health information in the methods mentioned above.

I **do not allow** Dr. McGregor and Associates to use my health information for any reason.

Patient Signature: _____Date: _____