PARAGON EYE ASSOCIATES

D. Todd Ford, M.D. • Michael Blair, M.D.
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PATIENT INFORMATION

First Name: _____ MI: ___ Last Name: _____ SSN: _____

Address: _____ Home: ( )

City: _____ State: _____ Zip: _____ Cell: ( )

Birth Date: _____ Marital: _____ Sex: _____ Emergency: ( )

Age: _____ Ethnicity: _____ Race: _____ Email: _____

EMPLOYER INFORMATION

Patient's Occupation: _____ Business Phone: ( )

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Spouse/ Parents if Minor: _____

Employer: _____ Business Phone: ( )

INSURANCE INFORMATION

☐ Medicare ☐ HMO ☐ PPO ☐ Other

Insurance Company (Primary): _____ Policy Holder: _____

Policy Holder's SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Insurance Company (Secondary): _____ Policy Holder: _____

Policy Holder's SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

REFERRAL INFORMATION

PRIMARY PHYSICIAN: _____ PHONE: ( )

PRIMARY EYE CARE DOCTOR: _____ PHONE: ( )

How did you hear about our practice? _____

What is the reason for your visit today? _____

Are you interested in LASIK? ☐ **YES** ☐ **NO**

PLEASE READ AND SIGN BELOW:

I hereby authorize the physicians and staff of Paragon Eye Associates to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to Paragon Eye Associates. I understand that I am financially responsible for ALL charges arising from services rendered to me by D. Todd Ford, MD PA DBA Paragon Eye Associates.

Signature: X _____ **Date:** _____

(OVER)

_____ /____/____

PATIENT'S NAME DATE

RELEASE OF THE INFORMATION

I hereby authorize Paragon Eye Associates to release information concerning my care for purposes of claims to my insurance company of third party payers in regards to my visits at this clinic for purposes of payment of claims.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ Date _____

OR

Signature of other
Responsible Person _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Paragon Eye Associates to Paragon Eye Associates.

I further hereby authorize payment directly to Paragon Eye Associates or D. Todd Ford, M.D., P.A. from my insurance company, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for services rendered. I understand that I am financially responsible to Paragon Eye Associates for charges not covered by this authorization.

I will cooperate in seeking, collecting and paying to Paragon Eye Associates all insurance proceeds. If the insurance proceeds cannot be paid directly to Paragon Eye Associates, I agree to collect payment and pay to Paragon Eye Associates within fifteen (15) days of receipt.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ Date _____

OR

Signature of other
Responsible Person _____ Date _____

REFRACTION POLICY

A refraction is the process of determining the eye's refractive error or need for corrective lenses.

It is an essential part of an eye examination if you are not seeing 20/20 unless you have a known condition diagnosed by the physician that impairs you from obtaining that level of vision. It is **not** a covered service by **Medicare** and **some insurance plans**. For those patients whose insurance does not cover this, a fee of $40 will be collected at the time of service, and this fee is collected in addition to the patient's co-payment at the time of your visit. **This fee does not include any professional fees for contact lens fitting or contact lens evaluations.**

ACKNOWLEDGMENT

I have read the above information and understand the refraction is a non-covered service. If a refraction is performed, I accept full financial responsibility for the cost of this service if not covered by my insurance. The co-payment is separate from and not included in the refraction fee.

Signature of Patient (Parent if minor) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or been given a copy of this practice's Notice of Privacy Practices, which provides me a complete description of the uses and disclosures of certain health information. I understand that I am entitled to receive a copy of this document.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintained. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature _____ Date _____

Name of Patient or Personal Representative

Relationship to Patient *(If signed by a personal representative of patient)* _____

The following persons can have access to my protected health information on a routine basis. I give permission for Paragon Eye Associates to share my protected health information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

PATIENT HISTORY QUESTIONNAIRE

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

PHARMACY: _____ **LOCATION** (street & city) _____

Drug Allergies: **Reaction:**

_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other
_____ Rash / shortness of breath / GI upset / other

□ **NO KNOWN DRUG ALLERGIES**

Past Ocular History: (Please mark all that apply) □ **None**

□ Cataracts □ Dry Eye Syndrome □ Retinal Detachment □ Macular Degeneration
□ Glaucoma □ Diabetic Retinopathy □ Keratoconus □ Sudden Vision Loss
Other _____

Ocular Surgeries: (Please mark all that apply **and** the date) □ **None**

□ Cataract Surgery _____ □ LASIK / PRK _____ □ Blepharoplasty _____
□ Retinal laser surgery _____ □ Strabismus surgery (eye muscle) _____
□ Glaucoma Surgery _____ □ Other _____

Past Medical History: (Please mark all that apply) □ **None**

□ High Blood Pressure □ Kidney Disease □ Heart Disease □ Asthma
□ Arthritis □ High Cholesterol □ Anemia □ Lupus
□ Seizures □ Stroke (Date)_____ □ Diabetes (Type I or II) □ Migraines
□ Thyroid Disease □ COPD □ Multiple Sclerosis
□ Cancer (type:_____) □ Other _____

Infections: (Please mark all that apply) □ **None**

□ Herpes Simplex □ Chicken Pox □ HIV / AIDS □ Syphilis
□ MRSA □ Herpes Zoster / Shingles □ Hepatitis A / B / C □ Meningitis
□ Other: _____

Past Surgical History: (Please list all surgeries and the dates) □ **None**

Surgery	Date	Surgery	Date

Medications / Eye Drops / Vitamins: (Please list all current medication) □ **None**

Medication	Dosage	Medication	Dosage

PARAGON EYE ASSOCIATES

NAME: _____ **DATE:** _____

Pregnant: (please circle) **YES / NO** **Breastfeeding:** (please circle) **YES / NO**

Family History: (please indicate on the line whether it pertains to Mother (M), Father (F), Siblings (S) and/ or Grandparents (G)

□ High Blood Pressure _____ □ Diabetes _____ □ Macular Degeneration _____
□ High Cholesterol _____ □ Cancer _____ □ Retinal Detachment _____
□ Stroke (CVA) _____ □ Arthritis _____ □ Blindness _____
□ Heart Disease _____ □ Cataracts _____ □ Glaucoma _____
□ Other: _____

Social History:

Smoking: □ current every day smoker □ social smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes, how much and how often? _____

Drug Use: □ Yes □ No If yes, what and how often? _____

Review of Systems: (Please mark all that apply) □ **None** □ **Other:** _____

Eyes
□ Contact Lenses
□ Pain
□ Double Vision
□ Dry Eyes
□ Flashes
□ Floaters
□ Droopy Eyelids

Ears, Nose and Throat
□ Vertigo
□ Ringing in ears
□ Hard of hearing

Cardiovascular
□ Chest Pain
□ Shortness of Breath
□ Dizziness
□ Fainting Spells
□ Irregular Heartbeat
□ Difficulty Lying Flat

Constitutional
□ Fever / Chills
□ Weight Gain / Loss
□ Fatigue/ Weakness

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitis

Genitourinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Difficulty Sleeping
□ Mood Swings

Endocrine
□ Increased Sweating
□ Increased Urination
□ Increased Hunger
□ Increased Thirst
□ Fingernail Changes

Blood / Lymph Nodes
□ Easy Bruising
□ Gums Bleed Easily
□ Prolonged Bleeding
□ Heavy Aspirin Use

Musculoskeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Eczema / Itching

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness / Tingling
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

Signature: _____ Date: _____

PARAGON EYE ASSOCIATES

Cataract Patient Questionnaire

Name: _____ Date: _____ Eye Being Evaluated ☐ RT ☐ LT

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependency on glasses. Each option has potential advantages and disadvantages, depending on your lifestyle and the activities you enjoy. Please help us to better understand what is important to you in order to determine which option is best suited for your lifestyle and eye health.

What is (or was) your occupation? _____

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?	**YES**	**NO**
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
2. Reading a newspaper or book?	☐	☐
3. Reading a large-print book, or large-print newspaper, or large numbers on a phone?	☐	☐
4. Recognizing people when they are close to you?	☐	☐
5. Seeing steps, stairs, or curbs?	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐
8. Writing checks or filling out forms?	☐	☐
9. Playing games such as bingo, dominos, or card games?	☐	☐
10. Taking part in sports like bowling, handball, tennis, or golf?	☐	☐
11. Cooking?	☐	☐
12. Watching television?	☐	☐

Symptoms

Have you been bothered by:	**YES**	**NO**
1. Poor night vision?	☐	☐
2. Seeing rings or halos around lights?	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐
4. Hazy and/or blurry vision?	☐	☐
5. Seeing well in poor or dim light?	☐	☐
6. Poor color vision?	☐	☐
7. Double vision?	☐	☐

Driving

1. Have you ever driven a car? □ YES (continue) □ NO (stop)
2. Do you currently drive a car? □ YES (continue) □ NO (stop)
3. How much difficulty do you have driving during the day because of your vision?
   □ No difficulty □ A moderate amount of difficulty
   □ A little difficulty □ A great deal of difficulty
4. How much difficulty do you have driving at night because of your vision?
   □ No difficulty □ A moderate amount of difficulty
   □ A little difficulty □ A great deal of difficulty
5. When did you stop driving?
   □ Less than 6 months ago □ 6-12 months ago □ More than 1 year ago

Other Activities

1. How many combined hours per day do you spend on a computer, tablet, and/or smartphone? _____
2. Please share anything else you think might be important about your lifestyle or daily activities: _____

   _____

   _____
3. Are there times in your day that you wish you didn't have to wear glasses? YES NO

   If yes, explain when: _____
4. After surgery, would you be interested in seeing well **without glasses** in the following situations?

   Distance Vision (driving, golf, tennis, other sports, watching television)

   ____ I prefer no distance glasses ____ I wouldn't mind distance glasses ____ I want distance glasses

   Mid-range Vision (computer, menus, price tags, cooking, board games, items of a shelf)

   ____ I prefer no mid-range glasses ____ I wouldn't mind mid-range glasses ____ I want mid-range glasses

   Near Vision (reading books, smartphones, tablets, e-readers, sewing, carpentry)

   ____ I prefer no near glasses ____ I wouldn't mind near glasses ____ I want near glasses
5. If you had to wear glasses after surgery, for which activity would you be **most** willing to use glasses?

   ____ **Distance vision** ____ **Mid-range vision** ____ **Near vision**
6. Please place an "X" on the following scale that best describes your personality:

   [----------I----------]

   Easy Going Perfectionist

Patient signature: _____