WELCOME TO OUR PRACTICE

Please fill out the following information completely:

KERRY SOLOMON, MD

1. Patient Information:

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Caucasian
☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School: _____

2. Guarantor Information: **Same as Above: ☐ Yes** **If patient is a minor please fill out.**

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School: _____

3. Insurance Information:

Primary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

Secondary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

4. Appointment Information:

Family Doctor: _____ Referring Doctor's Name: _____

Who is your eye doctor? _____

How did you hear about us? _____

List any family members who are patients: _____

_____

Emergency Contact:

Name: _____ Relationship: _____ Phone No: _____

Pharmacy:

Pharmacy Name: _____ Pharmacy Location: _____

Pharmacy Phone: _____

KERRY SOLOMON, MD

Patient Name: _____ DOB: _____

Eye History:

Have you experienced or been diagnosed with any of the following:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Dry Eyes
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Migraines
- ☐ Other _____

Please describe the reason for your visit:_____

_____

What activity would you look forward to most with improved vision? _____

Have you ever experienced a serious eye injury or had eye surgery? _____

Explain: _____

Date of your last exam: _____

Please list any eye drops or eye medications you are currently using: _____

_____

Medical History:

Do you have any medication allergies? _____

If so, please list: _____

Have you ever been diagnosed with any of the following?

- ☐ Asthma
- ☐ Stroke
- ☐ Thyroid
- ☐ Cancer
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Diabetes

Please list your current medications and dosages:

_____ _____ _____

_____ _____ _____

Please list prior major surgeries: _____

Have you ever had a flu shot? ☐ Yes ☐ No

Have you ever had a pneumonia shot? ☐ Yes ☐ No

Family History:

Has anyone in your immediate family been diagnosed with any of the following?

- ☐ Glaucoma
- ☐ Cataract
- ☐ Blindness
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Crossed or Lazy Eye

Social History:

Do you smoke? Yes / No If so, how many packs per day? _____

Has there been any change in your weight in the past 6 months? Yes / No Gain / Loss

Do you drink alcoholic beverages? Yes / No

If so, how much? Socially / With Meals / 2-3 Per Week / More _____

Are you pregnant or planning? Yes / No

Your Occupation: _____ Hobbies: _____

Reviewed with patient by:_____ On: _____

KERRY SOLOMON, MD

PATIENT VISUAL ASSESSMENT QUESTIONNAIRE

Patient Name: _____ DOB: _____ MRN #: _____

Please complete this form to assist us in better understanding your current visual state. Do your wear glasses or contact lenses?	**Yes** ☐	**No** ☐

If yes, please answer each question as if you are wearing your glasses or contact lenses.

1. **Does your distance vision seem impaired?** ☐ ☐
   If yes, for what activities is your distance vision most bothersome (check all that apply)
   ❑ Driving/traffic signs ❑ Watching TV/sports scores
   ❑ Store signs/menu boards ❑ Golf ❑ Tennis
2. **Does your near vision seem impaired?** ☐ ☐
   If yes, what activities is your near vision most bothersome (check all that apply)
   ❑ Reading books/newspaper ❑ Writing checks/completing forms
   ❑ Food labels/recipes ❑ Sewing/knitting ❑ Carpentry
3. **Are you bothered by glare and or halos when driving?** ☐ ☐
   If yes, when do you notice it the most?
   ❑ During the day due to sunlight ❑ At night due to bright lights ❑ Both

Have you ever had cataract surgery?

If you've had cataract surgery and have answered yes to any of the questions above, you may need a YAG laser treatment. Following cataract surgery, the capsule that holds the lens can develop a layer of new cells that form a clouding on the back surface of the lens. This is called posterior capsular opacification (PCO) or an 'after-cataract' and can occur in up to 50% of patients after cataract surgery. The YAG treatment is a quick and painless procedure that uses laser to clear those new cells.

The Yag Laser can almost always be safely postponed until you feel you need better vision. Are you ready to proceed with the Yag Laser procedure?	☐	☐

Patient Signature: _____ Date: _____

KERRY SOLOMON, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient name: _____ DOB: _____

Signature (of Patient or Legal Guardian): _____

Date: _____

*****I authorize the following to have access to my complete health records:**

_____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

Date:	Initials:	Reason:

KERRY SOLOMON, MD

WHAT IS A *REFRACTION*?

Refraction refers to the testing used to determine your best possible vision in each eye. Your doctor recommends refraction at the time of your annual exam or anytime you present with a visual complaint.

A visual complaint cannot be addressed without this service, and we cannot prescribe glasses or contacts if refraction is not performed.

If you are considering cataract surgery, a refraction must be performed within 90 days of surgery.

The fee for refraction is **$60.00** and **is not** covered by most insurance carriers.

I hereby acknowledge that I have read the above. I understand that if I elect to have a refraction performed, I will be responsible for a fee of $60.00 at the time of the service. I also understand that if I decline this service, I will not receive a prescription for glasses and/or contacts nor will I be able to proceed with cataract surgery.

❒ Accept

❒ Decline

Signature of Patient

Date

KERRY SOLOMON, MD

FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

I understand that it is the patient's responsibility to supply CAROLINA EYECARE PHYSICIANS, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my Insurance may not cover this appointment. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees. I authorize CAROLINE EYECARE PHYSICIANS, LLC to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

I understand that Medicare and most Insurance companies do not cover standard care or eye refraction (eyeglass prescriptions) and that I will be fully responsible for these charges. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

Most insurance companies do not cover the contact lens fitting or contact lens modification. The contact lens modification is a yearly charge that is separate from the eye exam charge. I understand that I am responsible for this additional charge.

I understand that a comprehensive eye exam involves dilation of the pupil, which may temporarily blur my vision for several hours. I recognize that operation of a motor vehicle after dilation may be hazardous and I have made appropriate arrangements.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, MC, VISA, AMERICAN EXPRESS, AND DISCOVER.

1) Date: _____ Signature _____

I authorize CAROLINA EYECARE PHYSICIANS, LLC to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of CAROLINA EYECARE PHYSICIANS, LLC to furnish information to insurance carriers or other doctors concerning my illness and treatment. They may also obtain pre-certification and prior authorization when necessary.

2) Date: _____ Signature _____

Reviewed by: _____