# WELCOME TO OUR OFFICE

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

NICKNAME: _____ Mr. Mrs. Ms. MISS Dr. MARITAL STATUS: S M D W DP

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ ☐ SAME AS HOME EMAIL: _____

PATIENT DATE OF BIRTH: _____ PATIENT SS#: _____

PATIENT EMPLOYER/SCHOOL: _____ F.T. STUDENT: Y/N

PATIENT OCCUPATION / GRADE: _____

FAMILY PHYSICIAN (PCP): _____ DR.'S PH# _____

LAST MEDICAL EXAM: _____

FORMER EYECARE PROFESSIONAL: _____ LAST EXAM: _____

DO YOU WEAR: ☐ GLASSES ☐ SUNGLASSES ☐ CONTACT LENSES TYPE: _____

HAS ANY MEMBER OF YOUR FAMILY BEEN OUR PATIENT? _____

ARE YOU INTERESTED IN REFRACTIVE SURGERY FOR VISION CORRECTION? Y/N

WHO MAY WE THANK FOR REFERING YOU TO US? _____

FINANCIALLY RESPONSIBLE / INSURED: LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ LAST 4 SS#: _____

NAME OF VISION INSURANCE: _____ ID #: _____

NAME OF MEDICAL INSURANCE: _____ ID #: _____

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PLEASE NOTE: WE BILL INSURANCE COMPANIES AS A COURTESY. INSURANCE AUTHORIZATIONS MAY NOT BE A GUARANTEE OF PAYMENT. I HERBY AUTHORIZE PAYMENT DIRECTLY TO DR. KRISTOPHER SKROMME FOR ANY INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, FOR SERVICES AND MATERIALS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AT TIME OF SERVICE THAT ARE NOT COVERED BY MY INSURANCE.

LONG TIME AUTHORIZATION/FINANCIAL RESPONSIBILITY / "SIGNATURE ON FILE"

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

(PLEASE TURN FORM OVER)

# TWO TREES OPTOMETRY KRISTOPHER R. SKROMME, OD
# 801 S. VICTORIA AV, SUITE 206 - VENTURA, CA. 93003
# RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses in detail. You are free to refer to this notice at any time before you sign this form. As described in **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to theses suggested restrictions. If we agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the **Notice of Privacy Practices from Dr. Skromme.**

_____ _____

Patient / Parent-Guardian Signature Date

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

# TWO TREES OPTOMETRY - KRISTOPHER R. SKROMME, OD

## 801 S. VICTORIA AV, SUITE 206 - VENTURA, CA. 93003

Patient Health History

Name: _____ DOB: _____ Date: _____

Briefly state any visual problems: _____

_____

Do you wear glasses? ☐ NO ☐ YES

Do you wear contacts? ☐ NO ☐ YES Are you interested in wearing contact lenses? ☐ NO ☐ YES

**Patient Eye History**

Indicate if any of these conditions apply to you:

☐ Cataract ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Lazy Eye ☐ Drooping Lid ☐ Other _____

List any eye injuries and/or eye surgeries (ie. Cataract surgery, LASIK, ect.) please include dates and which eye: _____

_____

_____

Indicate if you are currently experiencing any of these symptoms:

| | | | |
|---|---|---|---|
| ☐ Redness | ☐ Tearing/Watering | ☐ Double Vision | ☐ Foreign Body Sensation |
| ☐ Floaters | ☐ Dryness | ☐ Glare/Light Sensitivity | ☐ Eye pain/soreness |
| ☐ Flashes | ☐ Itching | ☐ Mucous Discharge | ☐ Loss of Vision |

Further explanation, if needed: _____

_____

**Patient Medical History**

Indicate if any of these conditions apply to you:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Diabetes | ☐ Stroke | ☐ Allergies | ☐ Depression | ☐ Sinus Congestion | ☐ Vascular Disease. |
| ☐ High Blood Pressure | ☐ Thyroid | ☐ Seizures | ☐ Bronchitis | ☐ Migraines | ☐ HIV/AIDS |
| ☐ Cholesterol | ☐ Cancer | ☐ Ashtma | ☐ Hepatitis | ☐ Anemia | ☐ Other _____ |

Further explanation, if needed: _____

_____

List any medications you take (including oral contraceptives, asprin, over the counter medications, and home remedies)

_____

_____

Do you have any allergies to medications ☐ No ☐ Yes If yes, explain: _____

**Family History**

Indicate any family history (blood relative) of the following conditions, and their relationship to you:

| | |
|---|---|
| ☐ Cancer _____ | ☐ Cataract _____ |
| ☐ Retinal Detachment _____ | ☐ Diabetes _____ |
| ☐ Glaucoma _____ | ☐ High Blood Pressure _____ |
| ☐ Macular Degeneration _____ | ☐ Other _____ |

**Patient Social History**

Do you use tobacco products? ☐ No ☐ Yes If yes, type: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type: _____

Women Are you pregnant? ☐ No ☐ Yes Are you breastfeeding? ☐ No ☐ Yes

**Please sign below to acknowledge that this form is correct.**

Signature: _____