DR. MCGREGOR &ASSOCIATES

Dr. Brent Collins | Dr. Randall Baughman | Dr. Nicholas Baughman

WELCOME TO OUR OFFICE!

Name: ____ Today's Date:_________________________

Address: __________________________________ City: _________________ State: ____ Zip: _______

Sex: M __ F__ SS#: ____ -___-_____ Birthdate: _____________Race: ______ Language___________

Home #: (____) ___________________Work #: (____) ______________Cell:(____) _________________

Employer: _______________________________

Emergency Contact Name & #: __________________________ Relationship to Patient: _____________

Family Physician Name & Phone Number: ______________________________

Email Address: ____

Insurance:

Insurance Name:____________________________ ID#: _____________________ Group #:___________

Policy Holder's Name: ______________________________ Policy Holder's DOB: ________________

Policy Holder's SSN#: ______________________________ Relationship to Patient: _________________

Referral Source: How did you hear about us? _______________________________________

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
Other	

Medications: Please list ALL
For Diabetic Patients Only **Recent Hemoglobin A1C :** **Date Test Performed:**

Medical History
Are you allergic to any medications? Please list if any:_________________ ___________________________
Are you Pregnant? Y N
Please list any health Conditions:
Physician treating you: Last Physical:

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

******Please review the back side******

Have you had any of the following eye problems? Circle all that apply:		Social History	
Burning	Dryness	Do you work at a computer for long periods?	YES NO
Sensitivity to light	Sudden Loss of Vision	Do you have more than one pair of current prescription glasses?	YES NO
Eye Surgery	Eye Strain	If you wear glasses, are you interested in thinner lighter lenses?	YES NO
Cloudy Vision	Recurring Infection	Do you wear bifocals?	YES NO
Blurry near vision	Itching	If so are you bothered by head tilting, restricted areas of vision correction, etc.?	YES NO
Flashes of Light	Soreness	Do you drink alcohol ?	YES NO
Redness	Watery Eyes	Do you Smoke?	YES NO
Gritty feeling in your eyes	Double Vision	How Much?	________
Objects floating in your vision	Seeing at night	Do you spend a lot of time outdoors?	YES NO
Eye Injury		Do you have sunglasses filtering 100% of UV rays?	YES NO
Seeing in the distance		Are you bothered by glare or reflection particularly while driving at night?	YES NO
Halo's around lights		Are you planning to get new contact lenses today?	YES NO
Comments:		Are you planning to get new glasses today?	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# : ______________________________

1. Dr. McGregor and Associates has permission to release any information concerning my condition and treatment to my medical or vision 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.
5. I give permission for Dr. McGregor and Associates to call and leave messages on my home / cell / Email & work numbers.

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:** _______________________________

******Please review the next page******

Elective Screening Procedures
(Not applicable for prior Glaucoma Patients & Patients under 21)

In keeping with our mission to provide the latest technology in caring for your eyesight,
Your Physician Recommends three elective procedures-digital retinal imaging and laser glaucoma screening.

The **digital retinal camera screening:** This screening allows us to detect early signs of diabetic retinopathy, macular degeneration, retinal tears or detachments, and other vision threatening conditions.
OCT of the Optic Nerve: This screening measures the thickness of the nerve fiber layer. This allows us to evaluate early signs of disorders to the optic nerve, such as glaucoma, which will reduce the chance of irreversible blindness.
OCT of the Macula: This screening measures the thickness of the retinal layer in order to detect early signs of macular degeneration or diabetic retinopathy. Floaters can also be evaluated with this screening

The cost for each procedure is $19.00 or $50.00 for all three. This is an additional, out of pocket expense, and is not covered by vision or medical insurance. (If , your optometric physician detects a medical condition that requires diagnostic testing or documentation, one or both of your selected elective screenings may be converted with further scans to complete the diagnostic medical test. The cost will be higher for the medically needed diagnostic test than the screening price. The medical scans can be filed to your medical insurance which may pay for some or all of the charge.)

______I elect to have ***ALL 3*** procedures for $50.00
______I decline these additional services

_____I elect the $19.00 digital retinal imaging
_____I elect the $19.00 OCT scan of the Optic Nerve
_____I elect the $19.00 OCT scan of the Macula

________ I need more information on the Elective Screenings

NOTICE OF YOUR HIPAA 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 (HIPAA). Our practice may use the following information in the following manners:

1. Treatment, payment, or health operations which may include filing of medical and vision insurance claims.
2. I allow Dr. McGregor and Associates to release any medical or demographic information to my medical or vision insurance companies to process any claim.
3. Appointment reminder calls to your home, work or cell numbers or voice mail you have provided.
4. Appointment reminder postcards by mail.
5. Notification by phone or mail of our practice's marketing or promotional offers.
6. Phone Calls, emails or text to notify that glasses or contacts have arrived.
7. I allow Dr. McGregor and Associates to release my glasses or contact prescription to another person or to another outside optical /contact vendors.
8. Phone calls pertaining to contact lens or glasses orders to phone numbers you have provided.
9. I allow________________________________ ________________________to receive any of my medical care information, financial information, appointment information or material pick up information.

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 contact 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.

Patient Signature: ____Date: ______________