

Dr. Jason Ritter, OD
Bryden Family Vision
939 Bryden Avenue, Lewiston, ID 83501

Patient Information

First Name _____	Street Address _____
Last Name _____	City _____
Phone Number _____	State _____
Email _____	Zip Code _____
S.S. Number _____	D.O.B. _____
Circle One: Male/Female	Circle One: Married/Single/Widowed/Child
Circle One: Indian or Native, African American, Hawaiian/Pacific Island, Asian, White, Hispanic	

Guardian Information (if patient is under 18 years of age)

First Name _____	Street Address _____
Last Name _____	City _____
Phone Number _____	State _____
Email _____	Zip Code _____

Primary Insurance Information

Policy Holder Information:	Primary Insurance:
Name _____	Carrier _____
Address _____	Policy Number _____
D.O.B. _____	Group Number _____
S.S. Number _____	Phone Number _____

Secondary Insurance Information

Carrier _____
Policy Number _____
Group Number _____
Phone Number _____

Additional Insurance Information

Carrier _____
Policy Number _____
Group Number _____
Phone Number _____

Financial Assignment

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due.

Acknowledgment of Notice of Privacy Practices (NPP)
(Included on back of this page)

- Yes, I have read or had explained to me by this office the NPP and I wish to continue my care under said terms.
- No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- The NPP could not be read due to the emergent nature of the care needed.



Bryden Family Vision

Jason Ritter, OD

939 Bryden Ave.

Lewiston, ID 83501

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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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 health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services 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 information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among 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 the 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 health care operations. By signing, you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

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

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Dated

Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient Print Name

Source of Authority

Patient History

Vision Correction History (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blurred Vision-Distance | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Sandy/Gritty feeling |
| <input type="checkbox"/> Blurred Vision-Near | <input type="checkbox"/> Halos | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Regular Headaches | <input type="checkbox"/> Strabismus (crossed eye) |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Infection or eye or lid | <input type="checkbox"/> Tired eyes |
| <input type="checkbox"/> Drooping eyelid(s) | <input type="checkbox"/> Itching | <input type="checkbox"/> Watery Eyes |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Loss of peripheral vision | |
| <input type="checkbox"/> Eye pain and/or soreness | <input type="checkbox"/> Loss of vision | |
| <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Mucus discharge | |

Family History (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Eye turn/lazy eye | <input type="checkbox"/> Retinal Detachment |

Personal Ocular History (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> PRK |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radial K |
| <input type="checkbox"/> Lasik Surgery | <input type="checkbox"/> Secondary Cataract |
| <input type="checkbox"/> Macular Degeneration | |

Glasses History (please check all that apply)

What glasses do you own?

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Backup pair | <input type="checkbox"/> Safety Glasses | <input type="checkbox"/> Incorrect prescription |
| <input type="checkbox"/> Bifocals | <input type="checkbox"/> Single Vision | <input type="checkbox"/> Need spare glasses |
| <input type="checkbox"/> Distance | <input type="checkbox"/> Sports Glasses | <input type="checkbox"/> Need sunglasses with UV |
| <input type="checkbox"/> Progressive | <input type="checkbox"/> Trifocals | <input type="checkbox"/> Problems with current glasses |
| <input type="checkbox"/> Reading | | <input type="checkbox"/> Problems with night vision |
| <input type="checkbox"/> Other: _____ | | |

How many hours a day do you spend using a computer? _____

Contact Lens History (please check all that apply)

- | | |
|---|--|
| What brand of contacts do you wear? _____ | <input type="checkbox"/> Interested in LASIK |
| How old are your current contacts? _____ | <input type="checkbox"/> Problems with current contacts |
| How often do you replace them? _____ | <input type="checkbox"/> Interested in colored contacts |
| What solution do you use? _____ | <input type="checkbox"/> I have never worn them, but I am interested in contacts |
| Do you wear them full or part time? _____ | |

Do you have any questions or concerns?

Patient Information

Date of last eye exam: _____

Last Eye Doctor: _____

Primary Care Physician: _____

Location: _____

List of Current Medications:

Allergies:

Have you had any recent surgeries, injuries or hospitalizations?

Do you have any of the following? (please check all that apply)

- | | | | | | | |
|--|---|---|--|---|--|-------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Headaches/Migraines | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Joint/Muscle Pain | | | |
| <input type="checkbox"/> Kidney Disease/Disorder | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Thyroid Disorder | | | | |
| <input type="checkbox"/> Other: _____ | | | | | | |

Please Circle All That Apply:

Tobacco Use: None Former Smoker Light Smoker(<1 pack per day) Heavy Smoker(>1 pack per day)

Alcohol Use: None Socially 1-2 Drinks Daily Above Average Use

Narcotic Use: None Recreational Use Chemical Dependence

WOMEN: Are you pregnant? YES/NO

Referral Information

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Social media | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Referred by a doctor | <input type="checkbox"/> Driving By |
| <input type="checkbox"/> Referred by a friend | <input type="checkbox"/> Phone Book |
- Name: _____

Preferred Method of Communication:

- | |
|--|
| <input type="checkbox"/> Personal Phone Call |
| <input type="checkbox"/> Text Message |
| Best # to reach you at: _____ |
| <input type="checkbox"/> Email |
| Address: _____ |