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
Employer: _____ Occupation: _____
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
Phone: (208) 743-1761
Fax: (208) 743-8042
dr.ritter@brydenfamilyvision.com

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)

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

Family History (please check all that apply)

- Blindness
- Cataracts
- Diabetes
- Eye turn/lazy eye
- Glaucoma
- Hypertension
- Macular Degeneration
- Retinal Detachment

Personal Ocular History (please check all that apply)

- Cataract Surgery
- Glaucoma
- Lasik Surgery
- Macular Degeneration
- PRK
- Radial K
- Secondary Cataract

Glasses History (please check all that apply)

What glasses do you own?

- Backup pair
- Bifocals
- Distance
- Progressive
- Reading
- Other:_____
- Safety Glasses
- Single Vision
- Sports Glasses
- Trifocals
- Incorrect prescription
  - Need spare glasses
- Need sunglasses with UV
- Problems with current glasses
- Problems with night vision

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? _____
How old are your current contacts? _____
How often do you replace them? _____
What solution do you use? _____
Do you wear them full or part time? _____

- Interested in LASIK
- Problems with current contacts
- Interested in colored contacts
- I have never worn them, but I am interested in contacts

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)
 Allergies Asthma Arthritis Anxiety Blood Disorder Cancer Depression
 Diabetes Epilepsy Gastrointestinal Heart Disease Headaches/Migraines
 High Blood Pressure High Cholesterol HIV/AIDS Joint/Muscle Pain
 Kidney Disease/Disorder Psychiatric Thyroid Disorder
 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
 Social media Internet
 Referred by a doctor Driving By
 Referred by a friend Phone Book

Preferred Method of Communication:
 Personal Phone Call
 Text Message
Best # to reach you at:_____
 Email
Address:_____