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Patient Intake Form

Patient Information

Patient Name: _____ Date of Birth: _____

SSN: ___-___-_____

Gender: ☐ Male ☐Female ☐Prefer Not to Answer

Preferred Phone: _____ ☐Cell ☐Home ☐Work

Secondary Phone: _____ ☐Cell ☐Home ☐Work

Email: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email ☐Letter

Address: _____

City: _____ State: _____ Zip: _____

Guardian(s) of Patient (If Applicable): _____

Martial Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Seperated ☐ Divorced ☐ Widowed

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Medical History

Primary Care Physician/Office: _____

Date of Last Visit: _____

Please Select Appropriate Answers & Answer EACH question:

Constitutional
Fever, Weight Loss/Gain ☐ Yes ☐ No ☐Unsure
Cancer ☐ Yes ☐ No ☐ Unsure

Gastrointestinal
Acid Reflux /GERD ☐ Yes ☐ No ☐ Unsure
Crohn's Disease ☐ Yes ☐ No ☐ Unsure

Ear, Nose, Mouth, Throat
Dry Throat/Mouth ☐ Yes ☐ No ☐ Unsure
Hearing Loss ☐ Yes ☐ No ☐ Unsure
Sunusitis ☐ Yes ☐ No ☐ Unsure

Neurological
Seizures/Epilepsy ☐ Yes ☐ No ☐ Unsure
Tension Headaches ☐ Yes ☐ No ☐ Unsure
Migraines ☐ Yes ☐ No ☐ Unsure
Tumor ☐ Yes ☐ No ☐ Unsure
Multiple Sclerosis ☐ Yes ☐ No ☐ Unsure

Psychiatric
Anxiety ☐ Yes ☐ No ☐ Unsure
Depression ☐ Yes ☐ No ☐ Unsure
Other ☐ Yes ☐ No ☐ Unsure

Vascular/Cardiovascular
Heart Disease ☐ Yes ☐ No ☐ Unsure
High Blood Pressure ☐ Yes ☐ No ☐ Unsure
Stroke ☐ Yes ☐ No ☐ Unsure

Respiratory
Asthma ☐ Yes ☐ No ☐ Unsure
Sleep Apnea ☐ Yes ☐ No ☐ Unsure
Emptsema ☐ Yes ☐ No ☐ Unsure
Chronic Bronchitis ☐ Yes ☐ No ☐ Unsure

Genitourinary
Pregnant ☐ Yes ☐ No ☐ Unsure
Nursing ☐ Yes ☐ No☐ Unsure
Prostate Disease ☐ Yes ☐ No ☐ Unsure

Endocrine
Type 1 Diabetes ☐ Yes ☐ No ☐ Unsure
AC1: _____ **Date**:_____
Type 2 Diabetes ☐ Yes ☐ No ☐ Unsure
AC1: _____ **Date**:_____
Thyroid Disease:
Hypothyroid ☐ Yes ☐ No ☐ Unsure
Hyperthyroid ☐ Yes ☐ No ☐ Unsure

Lymphatic/Hematologic
High Cholesterol ☐ Yes ☐ No ☐ Unsure
Anemia ☐ Yes ☐No ☐ Unsure

Bones/Joints/Muscles
Rheumatoid Arthritis ☐ Yes ☐No ☐ Unsure
Osteoporosis ☐ Yes ☐ No ☐ Unsure
Muscle/joint Pain ☐ Yes ☐ No ☐ Unsure

Integumentary
Shingles/Herpes Zoster ☐ Yes ☐ No ☐ Unsure
Cold Sores/ H.Simplex ☐ Yes ☐ No ☐ Unsure

Rosacea ☐ Yes ☐ No ☐ Unsure

Medical History

If you have a condition not listed, please explain and LIST ANY MEDICATIONS you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies).

_____

_____

_____

_____

Allergies (Medications or Other):

_____

_____

_____

_____

Ocular History

Date of Last Eye Exam: _____

Do you currently wear glasses? ☐ Yes ☐ No

➔ Are they for: ☐ Full time Wear ☐ Reading

☐ Driving Only ☐Computer

Contact lenses? ☐ Yes ☐ No

➔ If Yes, What Type of Contact Lenses: ☐ Soft Dailies ☐ Soft Monthlies

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☐ Soft Two Weeks ☐ [illegible] ☐ Other: _____

➔ If No, Are you Interested in Wearing Contacts? ☐ Yes ☐ No

Ocular History- Please Check All That Apply:

Loss of vision ☐ Yes ☐ No ☐ Unsure

Dryness ☐ Yes ☐ No ☐ Unsure

Blurred Vision ☐ Yes ☐ No ☐ Unsure

Mucus Discharge ☐ Yes ☐ No ☐ Unsure

Distorted Vision ☐ Yes ☐ No ☐ Unsure

Redness ☐ Yes ☐ No ☐ Unsure

Loss of Peripheral Vision ☐ Yes ☐ No ☐Unsure

Sandy or Gritty Feeling ☐ Yes ☐ No ☐ Unsure

Double Vision ☐ Yes ☐ No ☐ Unsure

Itching Glare/Light Sensitivity ☐ Yes ☐ No ☐ Unsure

Burning ☐ Yes ☐ No ☐ Unsure

Eye Pain or Soreness ☐ Yes ☐ No ☐ Unsure

Foreign Body Sensation ☐ Yes ☐ No ☐ Unsure

Chronic Infection of Eye or Lid ☐ Yes ☐ No ☐ Unsure

Excess Tearing/Watering ☐ Yes ☐ No ☐ Unsure

Styes or Chalazion Glaucoma ☐ Yes ☐ No ☐ Unsure

Flashes/Floaters in Vision ☐ Yes ☐ No ☐ Unsure

Cataracts ☐ Yes ☐ No ☐ Unsure

Retinal Disease ☐ Yes ☐ No ☐ Unsure

Lazy Eye ☐ Yes ☐ No ☐ Unsure

Eye Injury ☐ Yes ☐ No ☐ Unsure

Crossed Eyes☐ Yes ☐ No ☐ Unsure

If you answered YES to any of the above, or have a condition not listed. Please explain and list any medications or drops.

_____

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Social History

Do you drink alcohol? ☐ No ☐ Yes

If yes, how many times a week? _____

Do you use tobacco products (Includes E-cigarettes)? ☐ No ☐ No, Former Smoker ☐ Yes

If yes, how many times a week? _____

Do you use any recreational drugs? ☐ No ☐ Yes

If yes, how many times a week? _____

Family Medical History

Please Note ANY Family History (Parents, Grandparents, Siblings, Children…Living or Deceased) for the Following Conditions:

Cancer ☐ Yes ☐ No ☐ Unsure

Relationship _____

Cataracts ☐ Yes ☐ No ☐ Unsure

Relationship _____

Diabetes ☐ Yes ☐ No ☐ Unsure

Relationship _____

Macular Degeneration ☐ Yes ☐ No ☐ Unsure

Relationship _____

High Blood Pressure ☐ Yes ☐ No ☐ Unsure

Relationship _____

Glaucoma ☐ Yes ☐ No ☐ Unsure

Relationship _____

Thyroid Disease ☐ Yes ☐ No ☐ Unsure

Relationship _____

Crossed Eyes ☐ Yes ☐ No ☐ Unsure

Relationship _____

Heart Attack ☐ Yes ☐ No ☐ Unsure

Relationship _____

Amblyopia ☐ Yes ☐ No ☐ Unsure

Relationship _____

Stroke ☐ Yes ☐ No ☐ Unsure

Relationship _____

Retinal Detachment ☐ Yes ☐ No ☐ Unsure

Relationship _____

Vision & Lifestyle

Occupation: _____ Hours on Computer Per Day: _____

Hobbies or Sports: _____

What are your main goals for today's visit?

_____

_____

Insurance Information

Primary **VISION** Insurance: _____

Policy #: _____

Subscriber Name: _____ DOB: _____

Relationship: _____

Secondary **VISION** Insurance (If Applicable): _____

Policy #: _____

Subscriber Name: _____ DOB: _____

Relationship: _____

Primary **MEDICAL** Insurance: _____

Policy #: _____

Subscriber Name: _____ DOB: _____

Relationship: _____

Secondary **MEDICAL** Insurance (If Applicable): _____

Policy #: _____

Subscriber Name: _____ DOB: _____

Relationship: _____

Founders Eyecare — Notice of Privacy Practices

Effective Date: January 1st, 2025
Address: 4344 Woodlands Blvd, Suite 100, Castle Rock, CO 80104
Phone: (303) 688-3636
Email: fpvc@live.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- **Get a copy of your medical record** — You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- **Ask us to correct your medical record** — If you think your information is incorrect or incomplete, you may ask us to correct it.
- **Request confidential communications** — You can ask us to contact you in a specific way (for example, at work or by mail).
- **Ask us to limit what we use or share** — You can ask us not to use or share certain health information for treatment, payment, or our operations.
- **Get a list of those with whom we've shared your information** — You can ask for an accounting of disclosures for up to six years prior to your request.
- **Get a copy of this privacy notice** — You can ask for a paper or electronic copy of this notice at any time.
- **Choose someone to act for you** — If you have given someone medical power of attorney or have a legal guardian, that

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person can exercise your rights and make choices about your health information.

- **File a complaint** — If you believe your privacy rights have been violated, you can file a complaint with us or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information, let us know.

You have both the right and the choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a patient directory (if applicable).

If you are not able to tell us your preference (for example, if you are unconscious), we may share your information if we believe it is in your best interest or necessary to lessen a serious and imminent threat to health or safety. We **never** share your information for marketing purposes or sell your information without your written authorization.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- **Treatment:** We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an eye condition asks another healthcare provider about your overall health.
- **Payment:** We can use and share your health information to bill and receive payment from health plans or other entities.
  Example: We share information with your insurance company to process claims and verify benefits.
- **Healthcare Operations:** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use information about your care to evaluate our staff's performance and improve patient services.

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Other Uses and Disclosures

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We must meet many conditions before we can share your information for these purposes.

We may share information about you for:

- Public health and safety issues (disease prevention, product recalls, reporting adverse events, etc.)
- Research purposes (with appropriate authorization or de-identification)
- Compliance with laws and legal requests (court orders, subpoenas, law enforcement)
- Responding to organ and tissue donation requests
- Working with medical examiners or funeral directors
- Addressing workers' compensation, law enforcement, and other government requests
- Responding to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon request.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you give us permission, you may revoke it at any time

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Changes to This Notice

We may change the terms of this notice at any time, and the changes will apply to all information we have about you. The new notice will be available in our office and on our website upon request.

Acknowledgment of Receipt

Our office has agreed to bill the insurance company provided to us, on the date of services rendered. And accept payment on your behalf. Information we provide to you is based upon information given to us by your insurance carrier. This information is not a guarantee of payment by your insurance company. In the event that payment is not received, the patient is then responsible for payment. I have read, understand & accept the financial policy, patient acknowledgment & consent of notice of privacy practices.

Signature: _____ Date: _____

Patient or Guardian Name(Pr_____

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Questions or Concerns

If you have any questions or would like more information, please contact us at:

📍 **Founders Eyecare**
4344 Woodlands Blvd, Suite 100
Castle Rock, CO 80104
📞 **Phone:** (303) 688-3636
📧 **Email:** fpvc@live.com

If you believe your privacy rights have been violated, you may file a complaint with our office or with:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.

Washington, D.C. 20201
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be penalized for filing a complaint.