Eric J. Smith, O.D.
Adrianne S. Dirr, O.D.
4102 Roosevelt Boulevard
Middletown, Ohio 45044
(513) 425-0817
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Advancedeye1@yahoo.com

Patient Information

(Please print & complete both sides)

Date: ____

First Name: ___________________________________

Middle Name: _________________________________

Last Name: ___________________________________

Suffix: Senior/Junior/Other ______________________

Preferred/Nickname Name: _______________________

Street Address: ________________________________

City/State/Zip: ________________________________

Birthdate: _____________________________________

Sex (circle): Male Female

SSN: _______--_______--_______

Main Language (circle): English Spanish Other

Race: Decline or circle below

Caucasian Black Indian Asian Hispanic Other

Phone number (circle preferred):

Home: _______________________________________

Work: _______________________________________

Cell: ____

Email: _______________________________________

Insurance Information:

Medical Insurance: ____________________________

Subscriber Name: Self or _________________________

Subscriber Relationship (Circle): Spouse Parent

Subscriber Birthdate: ___________________________

Subscriber Address (circle): Same as Patient or below

Subscriber Street Address: _______________________

Subscriber City/State/Zip: ________________________

Subscriber Sex (circle): Male Female

Subscriber SSN (last 4 required): __________________

Subscriber Employer: ____________________________

Subscriber Phone (circle preferred):

Home: _______________________________________

Cell: ____

Vision Insurance: ______________________________

Subscriber Name: Self, Same as above, or ___________

Subscriber Relationship (circle): Spouse Parent

Subscriber Birthdate (if different): _________________

If Vision Subscriber information is different than previously noted please let us know.

Your email address will only be used for appointment reminders and occasional sale notifications.

Our Payment Policy: *Payment for services rendered and contact lenses is expected on the date of service. When ordering glasses, a deposit of ½ down is required and the balance is to be paid at pick up.*

We do not bill any third party other than insurance companies. The adult that brings in a child is the responsible party.

I understand and agree to the above policies.

Patient or Guardian Signature: **X**_________________________________ Date: _________________

(over)

Eric J. Smith, O.D.
Adrianne S. Dirr, O.D.

Acknowledgement of Receipt of HIPAA

I acknowledge that I have been offered or given a copy of the Notice of Privacy Practices for Advanced Eye Solutions, Eric J. Smith, OD & Adrianne S. Dirr, OD.

Printed Name: ____ Date:_____________

Patient (or Guardian) Signature: **X**____

Relationship to Patient (circle): Self Parent Spouse Other: ____________________________________

The following person(s)may receive disclosure of my protected health information:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

***This election remains in effect until the Notice of Privacy Practices is revised/revoked. ***

Patient Insurance Coverage Responsibility Disclaimer and Authorization

*I, ____, understand that it is **MY** responsibility to know if Advanced Eye Solutions is an authorized provider according to my insurance contract. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges.*

*I also understand that Advanced Eye Solutions is required by law and contract to collect from me, **ON THE DATE OF SERVICE**, any present copayment amount required by my insurance contract.*

If prior authorizations are required by my insurance contract for diagnostic testing and specialist's appointments, I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I authorize my insurance company, _________________________________, to pay all benefits directly to Advanced Eye Solutions and thereby agree to the release of relevant medication information to insurance carriers.

Signature of Patient (or Guardian): **X**________________________________ Date: ____________

This form is valid for one year from date of signature.

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ADVANCED EYE SOLUTIONS
Eye Disease • Contact Lenses • Childrens Vision • Emergency Care

Eric J. Smith, O.D.
Adrianne S. Dirr, O.D.

Medical History

Patient Name: ___________________________

Name & city of primary care physician ____________________________ Date of last physical _____________

Name & city of diabetic physician (if different from above) ______________________ Last exam ____________

Review of Symptoms – Have YOU been diagnosed or treated for any of the following body conditions?

Constitutional
Developmental Disabilities Y N
Cancer (type/year) _________ Y N
Other _______________ Y N

Ear, Nose, Throat
Hearing Loss Y N
Sinus Problems Y N
Chronic Ear Infections Y N
Other _______________ Y N

Neurological
Multiple Sclerosis Y N
Epilepsy Y N
Cerebral Palsy Y N
Stroke/CVA Y N
Migraines Y N
Headaches Y N
Autism Spectrum Disorder Y N
Dementia/Alzheimer's Y N
Other ________________ Y N

Psychiatric
Depression Y N
Attention Deficit Y N
Anxiety Y N
Bipolar Y N
Other ________________ Y N

Allergic/Immune
Lupus Y N
Sjogren's Syndrome Y N
Rheumatoid Arthritis Y N
Other ________________ Y N

Cardiovascular
High blood pressure Y N
Heart Disease Y N
Vascular Disease Y N
Congestive Heart Failure Y N
Other ________________ Y N

Respiratory
Asthma Y N
Emphysema Y N
Chronic Obstruction (COPD) Y N
Sleep Apnea Y N
Other ________________ Y N

Genitourinary
Kidney Disease Y N
Prostate Disease Y N
Herpes Y N
Chlamydia Y N
Pregnant/Nursing Y N
Benign Prostate Hypertrophy Y N
Other _________________ Y N

Gastrointestinal
Crohn's Y N
Colitis Y N
Ulcer Y N
Acid Reflux Y N
Celiac Disease Y N
Other _________________ Y N

Musculoskeletal
Arthritis Y N
Osteoarthritis Y N
Fibromyalgia Y N
Muscular Dystrophy Y N
Ankylosing Spondylitis Y N
Gout Y N
Other ________________ Y N

Integumentary/Skin
Eczema Y N
Rosacea Y N
Psoriasis Y N
Herpes Simplex/Cold Sores Y N
Herpes Zoster/Shingles Y N
Other ________________ Y N

Endocrine
Adult Diabetes/Year _______ Y N
Juvenile Diabetes/Year ____ Y N
Thyroid Dysfunction Y N
Hormonal Dysfunction Y N
Other ________________ Y N

Hematologic/Lymphatic
Anemia Y N
High Cholesterol Y N
Bleeding disorder Y N
Other _________________ Y N
Environmental Allergies Y N
Drug Allergy (write at *) Y N

Please list all prescribed and over-the-counter medications along with the DOSAGE you are currently taking *including birth control and vitamins.* (If you have a list, please give it to the front desk to copy.)

____

____

Do you currently use: Alcohol Y N Tobacco products Y N Drugs (recreational) Y N

*Please list any medication you are allergic or have a bad reaction to ______________________________ **None**

Any latex sensitivity? Y N

(over)

Eric J. Smith, O.D.
Adrianne S. Dirr, O.D.

Family medical history: have your **M**other, **F**ather, **B**rother, **Sis**ter, **D**aughter, or **Son** been treated/diagnosed with any of the following conditions? (Circle the family member with the condition.)

Cancer: M F B Sis D Son	Cataracts: M F B Sis D Son
Adult Diabetes: M F B Sis D Son	Macular Degeneration: M F B Sis D Son
Juvenile Diabetes: M F B Sis D Son	Glaucoma: M F B Sis D Son
High Blood Pressure: M F B Sis D Son	Retinal Detachment: M F B Sis D Son
Overactive Thyroid: M F B Sis D Son	Lazy Eye: M F B Sis D Son
Underactive Thyroid: M F B Sis D Son	Blindness: M F B Sis D Son

What is the main reason you are here today?

Routine Checkup/No real problem Y N   Want new glasses Y N   Difficulty seeing Y N

Other reason (Describe in your own words.): ____________________

Date of last eye examination: ____________ Doctor ____________

Do you have glasses now? Y N   How old are the glasses? ____________

Do you wear contacts now? Y N   Would like to know my contact lens options Y N

Review of Eye problems: do you have or frequently experience any of the following with your eyes?

Blur at Distance	Y N	Double Vision	Y N	Red Eyes	Y N	Eye Injury	Y N
Blur at Near	Y N	Crossed/Lazy Eyes	Y N	Mucous/Crusting	Y N	Eye Surgery	Y N
Blindness	Y N	Flashes/Floaters	Y N	Burning/Itching	Y N	Cataracts	Y N
Loss of Vision	Y N	Eye Pain/Tired eyes	Y N	Sandy/Gritty	Y N	Glaucoma	Y N
Glare/Light sensitive	Y N	Macular Degeneration	Y N	Dry Eyes	Y N	Watery Eyes	Y N
Retinal Detachment	Y N						

Contact Lens History

Please circle the type of contact lens you currently wear:

Disposable (soft): Daily replacement 2-week replacement Monthly replacement Other: ____________

Rigid Gas Permeable (Hard)

What brand of contact lens do you wear? ____________________

Toric/Astigmatism? Y N   Bifocal? Y N   Monovision? Y N

How many hours per day do you wear your contacts? ____________ Do you sleep in them? Y N

How old is your current PAIR of contacts? ____________________

What brand of contact solution do you use? Optifree Renu Biotrue Revitalens ClearCare Boston Other

Are you allergic to any brand of solution? ____________________

Please list any problems you have with your current contact lenses: ____________________

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