Dr. Tracey Dexter
Optometrist
209 West 15th Street
Hopkinsville, KY 42240

With my consent, Dr. Tracey D. Dexter may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Dr. Dexter's *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review and receive a copy of the *Notice of Privacy Practices* prior to signing this consent.

Dr. Dexter reserves the right to revise the *Notice of Privacy Practices* at anytime. A revised *Notice of Privacy Practices* may be obtained by a written request to the attention of the Privacy Officer at the above address.

With my consent, this office and staff may call my home or other designated locations and leave a message on voice mail or with someone at these locations in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, this office may mail to my home or other designated locations any items that assist the practice in carrying out treatment, payment and healthcare operations.

Dr. Dexter and her staff restricts how it uses or discloses my protected health information to carry out treatment, payment and healthcare. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Dexter's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that my health care will not be affected, however I will be responsible for the payment.

_____
Signature of Patient or Legal Guardian

_____ _____
Printed Name or Patient Date

The privacy and security of your personal health information is important to us. Any information that we collect on your behalf will be kept confidential in our office. A copy of your Rights is posted in the office.

Patient Information:

Name: (Mr.)(Mrs.)(Miss) _____ Home Phone_____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Social Security #_____ Age:_____Date of Birth_____Sex: M F

Name of Employer _____ Work Phone #_____

In Case of Emergency Notify: _____ Phone #_____

What is the reason for your visit today?_____
Are you pregnant and/or nursing? Yes or No

If insurance is not in your name, please complete the following questions:

Name of Insured: _____DOB:_____SS#_____

Address (if different): _____ Phone #_____

Employer: _____ Relationship to Patient:_____

I understand that I am financially responsible for all charges whether or not paid by insurance. If a claim is submitted to insurance on your behalf, your health information may be shared with them. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits.

Signature _____ Date:_____

Do you presently wear glasses? Yes No; Contact Lenses? Yes No
Are you interested in wearing contact lenses? _____ Date of last eye exam:_____
Are you interested in information regarding laser surgery? Yes No
Name of last eye doctor / clinic:_____ Name of medical doctor:_____

Place an "X" to indicate if YOU have had any of the following:

❑ Cataracts
❑ Blurred vision
❑ Eye injury
❑ Eye surgery
❑ Eye strain
❑ Eye pain
❑ Fainting spells or blackouts
❑ Floaters or spots
❑ Loss of vision
❑ Dizzy spells
❑ Double vision
❑ Discharge from eyes
❑ Dry eyes
❑ Eye infection
❑ Headaches
❑ Migraine headaches
❑ Light sensitivity
❑ Poor color vision
❑ Redness
❑ Retinal Detachment
❑ Sandy or gritty feeling
❑ Seeing flashes
❑ Seeing halos
❑ Itchy, burning, watering eyes
❑ Vision Therapy

Health History

Place an **"X"** to indicate if **you** or a **blood relative** has had any of the following:

	Yourself	Family		Yourself	Family
AIDS/HIV	_____	_____	Hepatitis (Type_____)	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Artificial Heart Valve	_____	_____	High Cholesterol	_____	_____
Pacemaker	_____	_____	Histoplasmosis	_____	_____
Heart Condition	_____	_____	Kidney Disease	_____	_____
Asthma	_____	_____	Lupus	_____	_____
Cancer	_____	_____	Macular Degeneration	_____	_____
Connective Tissue	_____	_____	Retinal Disease	_____	_____
Disorder	_____	_____	Rheumatic Fever	_____	_____
Diabetes	_____	_____	Shingles	_____	_____
Emphysema	_____	_____	Skin Conditions	_____	_____
Epilepsy	_____	_____	Stroke	_____	_____
Glaucoma	_____	_____	Thyoid Disease	_____	_____
Tuberculosis	_____	_____	Vascular Disease	_____	_____
Turned Eye	_____	_____	Other _____		

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Do you have any allergies? Yes No If so, what?_____

_____

List any medications you are allergic to: _____

Informed Consent for Pupillary Dilation:

Dilation of the pupils is necessary in order to fully evaluate the health of your eyes. In fact, dilation is absolutely required to fully examine the interior of the eye because without it only about 30% of the retina can be seen. Therefore, many diseases and potentially sight-threatening conditions will not be diagnosed unless this procedure is performed. The main side effects of dilation are blurry near vision and an increased sensitivity to bright lights. The procedure is painless and the effects last approximately two to four hours. Most, but not all patients are still able to drive while their eyes are dilated. I strongly recommend having this procedure done so that I can fully assess the health of your eyes. Please check one:

_____ YES, I agree to have my pupils dilated

_____ NO, I do not consent to having my pupils dilated. I assume responsibility for scheduling an appointment if I decide to have my eyes dilated at a later date.

ADDITIONAL COMMENTS:

_____

_____

_____

Who referred you to Dr. Dexter _____