

Dr. Trenton Warner and Dr. Kendon Seamons

PATIENT INFORMATION

Date	Home Phone (Ce	ell Phone ()		
May Emmett Eye Cente	r remind you of you	r appointmen	t via TEXT MES	SAGE and/or E-MA	AIL? YES	□ NO
Name			Pre	eferred Name		
LAST	FIRST	M	IDDLE INITIAL			
Address						
City		E-M	1AIL			
State	Zip		\square M	arried	ed 🗆 Single	\square Mino
Sex ☐ Male ☐ Female Age	Birth date:			eparated Divorce	ed	
	Spouse Name Spouse Employer					
				mployer Phone (
Whom may we thank for referring	you?			inprojer i none (
Emergency Contact						
KE	STUNSIBLE	ARTIX	FRIMARI	INSURANCE		
<u>Kr</u>	ESPONSIBLE I	ARTY	PRIMARY	INSURANCE		
Person Responsible for the Accoun						
	LAST			RST		LE INITIAL
Relation to Patient	LAST Birtl			Social Security	#	
Relation to PatientAddress (if different from patients)	LAST Birtl			Social Security Phone Number	#	
Relation to Patient Address (if different from patients) City	LAST Birtl		Zip	Social Security Phone Number Cell Number (#	
Relation to Patient Address (if different from patients) City Person Responsible Employed by _	Birtl State		ZipBusine	Social Security Phone Number Cell Number Sess Phone Number Cess Phone Phone Number Cess Phone Ph	#)	
Relation to Patient Address (if different from patients) City Person Responsible Employed by Policyholder Name:	BirtlState	Birth dat	Zip Busine e	Social Security : Phone Number Cell Number (ess Phone Number (Social Security #	#)	
Relation to Patient Address (if different from patients) City Person Responsible Employed by _ Policyholder Name: Insurance Company	BirtlState	Birth dat	Zip Busine e oup #	Social Security : Phone Number Cell Number Social Security # Subscriber #	#)	
Person Responsible for the Account Relation to Patient Address (if different from patients) City Person Responsible Employed by Policyholder Name: Insurance Company Names of other dependents covered	BirtlState	Birth dat	Zip Busine e oup #	Social Security : Phone Number Cell Number Sess Phone Number Social Security # Subscriber #	#)	
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Non-Covered Services

Medicare has issued regulations that require you to authorize services that we render to you and requires us to inform you of Non-Covered Services. The following services are not presently covered by Medicare: Routine eye examinations, refraction for glasses or contact lenses, *except one pair per year for Aphakia*, lens tints, coatings, lens options such as progressive lenses and wide bifocal lenses.

Authorization of Payments

I request the payment of authorized insurance benefits, including Medicare benefits, be made on my behalf to Emmett Eye Center for any services rendered to me by said office. I authorize release of my medical information to my insurance carrier and its agents in order to determine these benefits or information required for payment of services.

Signature on file

My signature also provides Emmett Eye Center with a long-term authorization to submit bills to my insurance, including Medicare on my behalf, with the understanding that I agree to pay for all services rendered to me not covered by Medicare or other insurance companies.

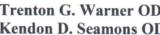
Finance Fees

Payment for charges NOT COVERED by insurance is PAYABLE IN FULL at the time of service. Finance charge of 1.5% will be added to accounts at a minimum charge of .50 per month.

Consent to treat a minor

I understand it is Emmett Eye Center's policy that all minor children receiving treatment must be accompanied by the parent/legal guardian. I authorize Emmett Eye Center to treat my minor child for appointments without my presence. I release Emmett Eye Center from any liability should something happen in my absence. I agree to be responsible for all services/charges provided for my child in my absence.

Minor's Name		_
Parent/Guardian Signature	Phone #	_
Privacy Practices Information		
The notice of Privacy Practices is available at all times.	Should I have any questions regarding the Notice of Priva	су
Practices a copy will be made available upon my reque	est.	
**Please list all individuals who may have access to you	ır medical/account information:	
		_
Signature of () Patient () Responsible Party	Date	





208-365-2020	EYE CENTER	Kendon D. Seamons OD
Name:	1	Birth Date:
Who is your primary care do	ctor?	
Please list medications you p	resently take (please include eye drop	os, vitamins and supplements)
Allergies:		
	N Do you, <u>or have you</u> used	
Do you, or have you used red	creational drugs or abused narcotic	es? Y/N
Medical History: Check when Amblyopia Blindness Eye Injury Glaucoma Macular Degeneration Retinal Detachment Strabismus **Other	Bleeding Tendencies Cancer Diabetes Heart Problems High Blood Pressure	Liver Disease Neurologic Pneumonia Stroke Thyroid Problems
Blindness Retinal Detachment		Cataract
DO YOU HAVE ANY PROBLEMS		

D

NO	YES	
NO		
NO		
NO	YES	
	NO NO NO NO NO	NO YES NO YES NO YES NO YES NO YES

Age-Related Macular Degeneration (AMD) Risk and Symptom Assessment

AMD is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive.

Risk factors for AMD There are several factors that may listed below. Check all that apply:	increase your risk of developing AM	1D, including the ones
☐ 50 years of age or older	☐ Current or past smoker	
☐ Family history of AMD	☐ Overweight	
☐ Caucasian (white)	☐ Heart disease, high blood pres	ssure and/or high cholesterol
Since poor night vision is a common so of minutes it takes you to adjust from and it can help us detect AMD at its examinutes to complete	bright light to darkness. This number	er is your RI, or Rod Intercept,
Early symptoms of AM Before any structural changes can be early symptoms. Check all that app	e seen in the back of your eye, you	ı may experience the following
☐ Difficulty seeing at night ☐	Difficulty driving at night	Difficulty reading in dim light
☐ Distorted / blurry vision ☐	Recent changes in vision	
Patient Name	Patient Signature	Date

