Emmett
EYE CENTER

Dr. Trenton Warner and Dr. Kendon Seamons

PATIENT INFORMATION

Date _____ Home Phone (____) _____ Cell Phone (____) _____

May Emmett Eye Center remind you of your appointment via TEXT MESSAGE and/or E-MAIL? ☐ YES ☐ NO

Name _____ Preferred Name _____
LAST FIRST MIDDLE INITIAL

Address _____ Social Security Number _____

City _____ **E-MAIL** _____

State _____ Zip _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex ☐ Male ☐ Female Age _____ Birth date: _____ ☐ Separated ☐ Divorced

Patient Employer _____ Spouse Name _____

Patient Employer Phone _____ Spouse Employer _____

Spouse Employer Phone (____) _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone (____) _____

RESPONSIBLE PARTY & PRIMARY INSURANCE

Person Responsible for the Account _____
LAST FIRST MIDDLE INITIAL

Relation to Patient _____ Birth date _____ Social Security # _____

Address (if different from patients) _____ Phone Number _____

City _____ State _____ Zip _____ Cell Number (____) _____

Person Responsible Employed by _____ Business Phone Number (____) _____

Policyholder Name: _____ Birth date _____ Social Security # _____

Insurance Company _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

_____

ADDITIONAL INSURANCE or VISION INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Policyholder Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patients) _____ Phone # (___) _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Business Phone Number (____) _____

Insurance Company _____

Social Security Number _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

_____

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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 Privacy Practices a copy will be made available upon my request.

***Please list all individuals who may have access to your medical/account information:*

_____

_____ _____

Signature of ( ) Patient ( ) Responsible Party *Date*

1108 S. Washington, Emmett, ID 83617
208-365-2020

Emmett EYE CENTER

Trenton G. Warner OD
Kendon D. Seamons OD

Name: **Birth Date:**

Who is your primary care doctor? _____

Please list medications you presently take (please include eye drops, vitamins and supplements) _____

_____

_____

Please list any surgeries you have had including eye surgery: _____

_____

Allergies: _____

Do you use alcohol? Y / N Do you, **or have you** used tobacco? Y / N

Do you, or have you used recreational drugs or abused narcotics? Y / N

Medical History: Check what applies to you

Amblyopia ____	Bleeding Tendencies ____	Liver Disease ____
Blindness ____	Cancer ____	Neurologic ____
Eye Injury ____	Diabetes ____	Pneumonia ____
Glaucoma ____	Heart Problems ____	Stroke ____
Macular Degeneration ____	High Blood Pressure ____	Thyroid Problems ____
Retinal Detachment ____	HIV ____	
Strabismus ____	Kidney Disease ____	

**Other _____

Family History: Please indicate who (for example) Father, Mother, Brother, Sister, Grandma/Grandpa, Aunt/Uncle

Blindness _____	Macular Degeneration _____	Glaucoma _____
Retinal Detachment _____	Strabismus _____	Cataract _____

**Other _____

DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS:

Loss of vision	NO	YES	_____
Blurred vision	NO	YES	_____
Double vision	NO	YES	_____
Dry eyes/Glare	NO	YES	_____
Mucus or redness	NO	YES	_____
Excess watering	NO	YES	_____
Eye pain	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 increase your risk of developing AMD, including the ones listed below. Check all that apply:

☐ 50 years of age or older	☐ Current or past smoker
☐ Family history of AMD	☐ Overweight
☐ Caucasian (white)	☐ Heart disease, high blood pressure and/or high cholesterol

Since poor night vision is a common symptom of AMD, we use the AdaptDx® to measure the number of minutes it takes you to adjust from bright light to darkness. This number is your RI, or Rod Intercept, and it can help us detect AMD at its earliest stages. The AdaptDx test is non-invasive and takes 5-10 minutes to complete

Early symptoms of AMD

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms. Check all that apply:

☐ 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

AdaptDx®