Heartland Eye Consultants
Adult Patient Demographics

Patient:
Last Name: ____ First Name: __________________________________ M.I. _______

Street Address: _________________________________ Apt #______ Gender: ☐ M ☐ F Date of Birth: _____/______/_______

City: ______________________ State: ________ Zip Code: ____________ Soc. Sec. No. ________-_________-____________

Cell: (_____) __________________ Home: (_____) __________________________ Work: (_____)___________EXT_______

Please provide your email address for appointment purposes only: **Email:**____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other________________ ☐ I decline.

Race: ☐American Indian or Alaska Native ☐Asian ☐African-American ☐Pacific Islander ☐White ☐Other Race ☐ I decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other__________________ ☐ I decline to answer this question.

Special Needs: ☐ Hearing Impaired ☐ Wheelchair ☐ Translator ☐ None ☐ Other___________________________________

Occupation: ____ Employer: ____

Employer's Address: ____________________________________ City, State, Zip: ______________________________ __________

Is this visit a result of an accident or illness *that occurred at work*? ☐ Yes ☐ No

Were you referred to our office by a doctor or doctor's office? ☐Yes ☐No If yes, who? _________________________________

Who performed your last eye exam? ____ Date: ______/______/_____

Family Physician: ____ Approx Location: ____________________________________

Emergency Contact: ________________________ Relationship: ______________ Phone: ___________________________________
(Not living in household) (Area Code)

If the patient is married, please complete spouse information:

Spouse's Last Name:________________________First Name:____________________ M.I.____ Birthdate: _______/______/_________

Cell Phone: __________________ Work Phone: _________________EXT______ **Email** ___________________________________

SSN:___________________ Employer: ________________________ Occupation________________Title: ______________________

Employer's Address:_____________________________________ City__________ ________ State__________Zip_______________

****Are you insured through a parent? If YES, please provide name and DOB**____

The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card.
For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment: Cash Check Credit Card (**Mastercard or Visa. We do not accept Discover or American Express**)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and that 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 In the event you fail keep your appointments or if you repeatedly reschedule your appointment with less than a 48 hour notice, a $50 deposit may be required prior to scheduling another appointment. This deposit will be credited to your bill if you keep the appointment as scheduled. If you fail to keep the appointment or reschedule again with less than 48 hour notice, you will forfeit the deposit.

****I authorize communication of my medical records to be released to:** ____

Authorized Signature: ____**Date of Signature:** _____________________

PLEASE INITIAL __________ **You have read and are aware of the HIPAA privacy policy and agree with its provisions.**

DRY EYE QUESTIONNAIRE – SPEED

Please answer the following questions by checking the box that best represents your answer.
Select only **one** answer per question.

1. Report the **FREQUENCY** of your symptoms using the rating list below: (Mark box with an X)
   0 = Never **1** = Sometimes **2** = Often **3** = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

2. Report the **SEVERITY** of your symptoms using the rating list below: (Mark box with an X)
   0 = No problems
   1 = Tolerable – not perfect but not uncomfortable
   2 = Uncomfortable – irritating but does not interfere with my day
   3 = Bothersome – irritating and interferes with my day
   4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

SCORE: ______/ 28

Do you use eye drops for lubrication? ☐ YES ☐ NO
If yes, how often? ____
What brand? ____

3. Have you been treated for a **Stye**? ☐ YES ☐ NO
4. Have you had any of these symptoms recently?
   ☐ EYELID REDNESS ☐ CRUSTING AROUND LASHES ☐ LID IRRITATION

5. Do your eyes itch? ☐ NEVER ☐ SOMETIMES ☐ FREQUENTLY ☐ ALWAYS
   If yes, do you have environmental allergies? ☐ YES ☐ NO

6. Do you wear contact lenses? ☐ YES ☐ NO
7. Is your eye discomfort the same between both eyes? ☐ YES ☐ NO
   If no, which eye is the most symptomatic? ☐ RIGHT ☐ LEFT

8. What hobbies do you have? ____

9. What do you do for work? ____

NAME (Please Print):________________________________ DATE:___________

Patient History

Dr. Holly Ternus
Dr. Robert Vandervort
Dr. Delaney Kent

Last:________________ First:________________
MI:___

Date of Birth:_____________ Age:________

Sex: M F

Ocular History:

Purpose of today's visit:

- ☐ Blurry Vision
- ☐ Headaches
- ☐ Redness/Burning
- ☐ Grittiness
- ☐ Double Vision
- ☐ Infection
- ☐ Dryness
- ☐ Night vision difficulty
- ☐ Flashes of light
- ☐ Eye Pain
- ☐ Floaters/spots in vision
- ☐ Tearing

When was your last eye exam?_________________

Do you wear contact lenses? Y N

Have you been diagnosed with the following?

- ☐ Cataracts
- ☐ Iritis/Uveitis
- ☐ Corneal abrasion
- ☐ Lazy Eye
- ☐ Dry Eye
- ☐ Macular Degeneration
- ☐ Eye Turn
- ☐ Retinal defect/hole/tear
- ☐ Glaucoma
- ☐ Retinal detachment
- ☐ Injury
- ☐ Other eye diseases

Has anyone in your family been diagnosed with the following?

- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Eye Turn
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal detachment
- ☐ Iritis/Uveitis
- ☐ Other eye diseases

Visual Needs Assessment:

Hours of screen usage per day: ________________

Hours of outdoor activity per day: _____________

Hobbies: ___________________________________

____

How many hours do you read before you experience fatigue? ______________

Circle if you have: eyestrain neck strain headaches

Who can we thank for your referral to our office?

____

Current Medications and Doses (include OTC):

____

____

____

____

____

____

Allergies:

____

List any prior *eye* surgeries and dates if known:

____

____

Are you pregnant or nursing? Y N

Do you use cigarettes? Y N If so, how often?_______

Do you drink alcohol? Y N If so, how often?________

Medical History:

Have you ever been diagnosed or treated for any of the following health problems? (If yes include diagnosis; otherwise, circle N for No and F for Family history)

Allergies	Y _______________	N	F
Arthritis	Y _______________	N	F
Blood/Lymph	Y _______________	N	F
Cancer	Y _______________	N	F
Cholesterol	Y _______________	N	F
Diabetes	Y _______________	N	F
Digestive/Gastric	Y _______________	N	F
Ears/Nose/Throat	Y _______________	N	F
Endocrine	Y _______________	N	F
Fatigue	Y _______________	N	F
Fevers	Y _______________	N	F
Heart Disease	Y _______________	N	F
High Blood Pressure	Y _______________	N	F
Immune	Y _______________	N	F
Integumentary (skin)	Y _______________	N	F
Kidney	Y _______________	N	F
Muscle or Bone	Y _______________	N	F
Neurological/Headaches	Y _______________	N	F
Psychological	Y _______________	N	F
Respiratory	Y _______________	N	F
Sinus	Y _______________	N	F
Stroke/Seizures	Y _______________	N	F
Throat Infections	Y _______________	N	F
Thyroid	Y _______________	N	F
Unusual Weight Changes	Y _______________	N	F