

	did you hear about our office? (Please check box and list name) Friend/Relative: Another Healthca		rovider:	
		Event/Other:		
GENERAL INFORMATION	27 × 27 A			
Name (Last, First, MI, Prefer				
Address:				
City, State, Zip:				
Social Security #			-	
Please	list your Phone #, then ch	eck which # you prefer t	to be contacted:	
□ Home:				
E-mail:				
			and the second s	
Race (please circle): Caucas	sian African American	Hispanic/Latino A	Asian Indian	
A77	cial American Indian			
Ethnicity (please circle): His	panic/Latino Not Hispar	nic/Latino		
Ethnicity (please circle): His	panic/Latino Not Hispar	nic/Latino		
Ethnicity (please circle): His Language:		nic/Latino		
Ethnicity (please circle): His		nic/Latino		
Language:				
Language:Employer (or School):	Occ	cupation (or Grade):		
Language:	Occ	cupation (or Grade):		
Employer (or School): Emergency Contact and Pholif married, name of spouse	Occ	cupation (or Grade):		
Language:Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY:	one #:If	cupation (or Grade): child, name of parents_		
Language: Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam:	one #:If	cupation (or Grade): child, name of parents_ n:		
Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam: Do you currently wear contact	Oco one #:If Doctor/Location act lenses?	cupation (or Grade): child, name of parents_ n: f yes, what kind?		
Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam: Do you currently wear contact	Oco one #:If Doctor/Location act lenses?	cupation (or Grade): child, name of parents_ n: f yes, what kind?		
Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? □ Ye	Occor/Location act lenses? □ Yes □ No. It	cupation (or Grade): child, name of parents_ : f yes, what kind? e they?		
Employer (or School): Emergency Contact and Pholif married, name of spouse HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Have you been experience	Doctor/Location act lenses? □ Yes □ No. If yes, how old are	cupation (or Grade): child, name of parents_ : f yes, what kind? e they?	e you interested in?	
Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Ye Have you been experience Blurred Vision	Occor/Location act lenses?	cupation (or Grade): child, name of parents_ : f yes, what kind? e they?		
Employer (or School): Emergency Contact and Pholif married, name of spouse HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Have you been experience	Doctor/Location act lenses? □ Yes □ No. If yes, how old are	cupation (or Grade): child, name of parents n: f yes, what kind? e they?	e you interested in? Contact Lenses Lasik	
Employer (or School): Emergency Contact and Pho If married, name of spouse_ HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Ye Have you been experience Blurred Vision	Occor/Location act lenses?	cupation (or Grade): child, name of parents n: f yes, what kind? e they?	e you interested in?	
Employer (or School): Emergency Contact and Pholif married, name of spouse HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Have you been experience Blurred Vision Flashes	Octor/Location act lenses?	cupation (or Grade): child, name of parents_ f yes, what kind? they? Are	e you interested in? Contact Lenses Lasik	
Employer (or School): Emergency Contact and Pho If married, name of spouse HEALTH HISTORY: Last eye exam: Do you currently wear contact Do you wear glasses? Have you been experience Blurred Vision Flashes Floaters	Occor/Location act lenses?	cupation (or Grade): child, name of parents n: f yes, what kind? e they? Are	e you interested in? Contact Lenses Lasik Computer glasses	

Current Medications (Include over-the-counter, eye drops/meds, vitamins, oral contraceptives)				
Have you experienced or been	n diagnosed or treated for: (If ye	s, check box and explain below)		
EYES	□ Stroke	GENITOURINARY		
□ Cataracts	□ Migraines	☐ Kidney Disease		
□ Glaucoma	□ Concussion	☐ Sexually Transmitted Disease		
☐ Macular Degeneration	PSYCHIATRIC	MUSCULOSKELATAL		
☐ Dry Eye Syndrome	□ Depression	□ Osteoarthritis		
☐ Retinal Tear/Detachment	☐ Anxiety Disorder	SKIN		
□ Lazy Eye	☐ Bipolar Disorder	□ Rosacea		
□ Eye Injury	CARDIOVASCULAR	☐ Eczema/Psoriasis		
☐ Eye Surgery/LASIK	☐ High Blood Pressure	ENDOCRINE		
CONSTITUTIONAL	☐ Heart Disease	□ Diabetes		
□ Developmental Disability	□ Vascular Disease	☐ Thyroid dysfunction		
□ Cancer	RESPIRATORY	HEMOTOLOGIC/LYMPHATIC		
EAR/NOSE/THROAT	□ Asthma	□ Anemia		
☐ Hearing Loss	□ COPD	☐ High Cholesterol		
□ Sinusitis	☐ Sleep Apnea	ALLERGY/IMMUNOLOGIC		
NEUROLOGICAL	GASTROINTESTINAL	☐ Rheumatoid Arthritis		
☐ Multiple Sclerosis	□ Crohn's, Colitis	□ Lupus		
OTHER:				
Please Explain:				
Primary Physician:	Clinic/Location:	Last Exam:		
	ossibility that you may be, pregnant			
Height: Weight:_				
	and the second s			
Allergies				
1,170 - 1,170 - 1,170	ons? Yes No. If yes:			
Do you have any environmental				
,				
Social History:				
Do you use any tobacco product	s? 🗆 Yes 🗆 No. How often	Have you ever smoked? □ Yes □ No		
	☐ Yes ☐ No. How often			
Is there a family history of an	y of the following? (Explain relat	tionship)		
□ Glaucoma	□ Type II Diab	etes		
☐ Macular Degeneration	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER	etes		
Cataracts	□ Hypertensio	on		
□ Retinal Detachment/Tear				
□ Lazy Eye	The state of the s	d		
□ Other Eye Disease		1		

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands the	at:			
The Practice has Notice of Printer practice reserves the right to in patient has the right to in the patient may revoke this	n may be disclosed or used for treatment, payment rivacy Practices and that the patient has the opport that to change the Notice of Privacy Practices. restrict the uses of their information, but the Practic Consent in writing at any time and all future discloss receipt of treatment upon the execution of this Con-	e does not have to a ures will then cease.	Notice. agree to those restrictions.	
This consent was signed by:	Printed Name (Patient or Responsible Party)	***************************************	Printed Name (Pract	ice Representative)
	Patient Signature or Responsible Party	Date	Signature	Date
	Relationship to Patient (if other than patient)			
AMERICAN GENERAL ENGLA PERSONAL PERSONAL PROPERTY OF THE PROPE		METERIA EN ENCOS REPORTANTO A ELEMANDO SERVICIO A ELEMANDO CONTRATOR DE LA		ert Alle Geschen (1964) voor 4 Verein Merit Aan 4 Eerst, Geschild die voor opgevouwere absoeke telle (1964) voor 1964 voor 196
	GUARANT	TEE OF ACCOUNT		
and the carrier, states that y	s payment for co-pays and deductibles at time of se you are responsible for co-pays and deductibles at the service. If your carrier has not paid your account with	ne time of service an	nd Performance Vision also has a	an agreement with your carrier to
hereby authorize and assig claims resulting from the lia	n payment directly to Performance Vision for any m bility of the third party until such time as the accoun	nedical benefits, inju nt is paid in full upon	ry benefits due because of third the completion of treatment.	party liability, or proceeds of all
By signing this form, I accep	t responsibility for reasonable costs incurred if my a	ccount becomes del	linquent. I have read, understar	nd and agree with the above.
x				
Signature of Patie	ent and/or Authorized Representative			Date
	PATIENT SIGNATURE AUTHOR	IZATION / RELEASE	OF INFORMATION	
respect to any physical or m determine eligibility for insu performing business or lega	rize Performance Vision to furnish any insurance contental condition and/or treatment of me or my child trance and eligibility for benefits under my insurance I services in connection with the claim, or as may be until rescinded in writing or replaced by one at a lat	. I understand the in e coverage. Any info e otherwise lawfully	nformation obtained by this aut ormation will not be released ex	horization will be used to ccept to persons or organizations
x				
Cignature of Dati	ant and/or Authorized Representative			Date

Signature of Patient and/or Authorized Representative



Retinal Photo Consent Form

Dear Patient:

As part of your eye exam, Dr. Winton recommends special diagnostic procedures to better examine your eyes for retinal diseases and glaucoma. This procedure consists of taking digital pictures of the back of the eye to evaluate the optic nerve, blood vessels, and tissues of the back of the eye. In some cases, these images can detect diabetic eye changes, macular degeneration, high blood pressure changes, and glaucoma. It will also serve as a baseline for comparison in future years.

If the doctors identify any medical health concerns, we will likely be able to bill the photos to your medical insurance; otherwise, the photos are an additional fee of \$38.00. While taking these images does not completely replace the need to have your eyes dilated, it is strongly recommended you have images taken. This ensures the doctors are able to get a reasonable view of the eye and your retinal health.

Yes, I want to have the retinal photos for my record, and I understand there will be my medical insurance cannot be billed.	a \$38 fee if
No, I do not want retinal photos taken.	
Undecided, I would like to discuss this with the Doctor.	
Signed:	
Patient name (or guardian if under 18):	
Date:	

Records Release

Date:					
To:					
Doctor/Physician					
Address:					
City:	State:		Zip:		
Phone:	Fax:	**********		-	
	Dr. Kenne 6511 Highw Owens Cross E-Mail: Offi Phone #: 2	ay 431, Su Roads, Al ce@pvhsv	ton uite A . 35763 v.com 5427		
Print name of patient		obecká kateriologicz dzieczów i otkorokowomie		Date of Bi	rth
Signature (patient, parent, guar	rdian)				