Drs. Hawks, Besler & Rogers
OPTOMETRISTS
Terry F. Hawks, O.D. L. Gregory Besler, O.D. Jason B. Rogers, O.D. Jon B. Stoppel, O.D.

PRINT EMAIL

Date:_____

NEW PATIENT FORM

GENERAL INFORMATION

Payment is due at the time of your examination. Please do not ask to be billed for professional services.

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

What would you like to be called? _____

Height: _____ Weight:_____

Birthdate: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email:_____

Occupation: _____ Employer:_____

Referred By (patient name): _____

or how did you find us? ☐ Drive by ☐ Google ☐ Facebook ☐ Other Website:_____

RESPONSIBLE PERSON (for Financial Statement) ☐ Same as above

Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Name of Responsible Person: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email:_____

AARA INFORMATION

Due to changes in healthcare privacy and healthcare reform laws, we are now required to gather certain information regarding your race and ethnicity. This information is required as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

PRIMARY LANGUAGE PREFERENCE
(select one)

- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Russian
- ☐ Other _____
- ☐ Patient declines to answer

RACE
(select one)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Patient declines to answer

ETHNICITY (select one)

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient declines to answer

DIABETIC PATIENTS ONLY

- ☐ HgbA1c (blood glucose)

Drs. Hawks, Besler & Rogers
OPTOMETRISTS
Terry F. Hawks, O.D. **L. Gregory Besler**, O.D. **Jason B. Rogers**, O.D. **Jon B. Stoppel**, O.D.

Date:_____

HEALTH HISTORY QUESTIONNAIRE

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____ Age: _____

What is the reason for your visit today? _____

REVIEW OF SYSTEMS

Are you currently being treated for, or have you ever been diagnosed with any of the following?

	NO	YES
CARDIOVASCULAR		
Arteriosclerosis	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
EAR, NOSE, MOUTH, THROAT		
Allergies, Hay Fever	☐	☐
Chronic Sinus Congestion	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Histoplasmosis	☐	☐
Obstructive Sleep Apnea	☐	☐
GASTROINTESTINAL		
Chronic Constipation	☐	☐
Chronic Diarrhea	☐	☐
Crohn's Disease	☐	☐
Diverticulitis	☐	☐
EYES		
Corneal Transplant	☐	☐
LASIK	☐	☐
PRK	☐	☐
Retinal Detachment	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
NEUROLOGICAL		
Chronic Headaches	☐	☐
Migraines	☐	☐
with Aura	☐	☐
IMMUNOLOGIC		
Lupus	☐	☐
HIV Positive	☐	☐
Lyme Disease	☐	☐
Herpes Simplex	☐	☐
Herpes Zoster	☐	☐
Other	☐	☐
MUSCULOSKELETAL		
Rheumatoid Arthritis	☐	☐
Chronic Joint & Muscle Pain	☐	☐
Gout	☐	☐
Myasthenia Gravis	☐	☐
HEMATOLOGIC/LYMPHATIC		
Anemia	☐	☐
Bleeding Disorder	☐	☐
Hemochromatosis	☐	☐
Leukemia	☐	☐
Lymphoma	☐	☐
Toxoplasmosis	☐	☐
GENITOURINARY		
Enlarged Prostate	☐	☐
Kidney Disorder	☐	☐

	NO	YES
ENDOCRINE		
Diabetes ☐ Type I ☐ Type II	☐	☐
Hyperthyroidism/Graves (overactive)	☐	☐
Hypothyroidism (underactive)	☐	☐
Hashimotos Thyroiditis	☐	☐
Polycystic Ovary Syndrome (P.C.O.S.)	☐	☐
SKIN		
Rosacea	☐	☐
Acne	☐	☐
Psoriasis	☐	☐
Albinism	☐	☐
Melanoma	☐	☐
Eczema	☐	☐
Other	☐	☐
PSYCHIATRIC		
ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Other	☐	☐

SOCIAL HISTORY

Please list usage or leave blank if not applicable.

☐ Tobacco _____

☐ Alcohol _____

☐ Drugs _____

☐ I would prefer to discuss with the Doctor.

MEDICATIONS

List your medications (include oral contraceptives, aspirin, over the counter medications and home remedies). We're happy to photocopy your list:

Do you have any allergies to medication or medical devices?

☐ No ☐ Yes If YES, please explain:

MISCELLANEOUS

Are you interested in learning about

Refractive surgery options? ☐ No ☐ Yes

Corneal Molding? ☐ No ☐ Yes

Are you pregnant or nursing? ☐ No ☐ Yes

When was your last eye exam?_____

By whom? _____

FAMILY HISTORY

Please note any personal or family history (parents, grandparents, siblings, children, living or deceased) for the following conditions.

Glaucoma
☐ No ☐ Yes (relation)_____

Cataracts
☐ No ☐ Yes (relation)_____

Macular Degeneration
☐ No ☐ Yes (relation)_____

Eye Injury
☐ No ☐ Yes (relation)_____

Retinal Injury/Disease
☐ No ☐ Yes (relation)_____

Other Ocular Disease
☐ No ☐ Yes (relation)_____

Blindness
☐ No ☐ Yes (relation)_____

Strabismus (Turning of the Eye)
☐ No ☐ Yes (relation)_____

Amblyopia (Lazy Eye)
☐ No ☐ Yes (relation)_____

Retinopathy
☐ No ☐ Yes (relation)_____

Cancer
☐ No ☐ Yes (relation)_____

Heart Disease
☐ No ☐ Yes (relation)_____

Hypertension
☐ No ☐ Yes (relation)_____

Cholesterol
☐ No ☐ Yes (relation)_____

Kidney Disease
☐ No ☐ Yes (relation)_____

Stroke
☐ No ☐ Yes (relation)_____

CONTACT LENS USERS ONLY

Please bring your current contact lens prescription or your contact lens box (for each eye if different).

What kind of contacts do you wear?

☐ Soft ☐ Gas Permeable

☐ Extended Wear ☐ Disposable

May we request information from your previous doctor? ☐ No ☐ Yes

Which contact lens solution do you use?

_____

Do you have a backup pair of glasses?

☐ No ☐ Yes

Please bring your glasses with you to the appointment.

Drs. Hawks, Besler & Rogers
OPTOMETRISTS
Terry F. Hawks, O.D. **L. Gregory Besler**, O.D. **Jason B. Rogers**, O.D. **Jon B. Stoppel**, O.D.

Date:_____

HIPPA PRIVACY PRACTICE/ CONSENT TO TREAT

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____ Birthdate: _____

Consent to Treat. I herby authorize Drs. Hawks, Besler & Rogers (Drs. HBR) to treat me/my child.

Requirements at time of service: I understand insurance cards must be presented at time of service or patient will be self-pay until cards are presented or if insurance changes within treatment, cards must be presented before Drs. HBR will file claims to new insurance. All co-payments, co-Insurance, deductibles and non-covered services are due at time of service. Not all services are a covered benefit. If your insurance company denies a service, the balance is due within 30 days. Verification of benefits is not a guarantee of payment. We do offer a discount on certain services if paid in full at the time of your appointment and if no insurance is filed.

Assignment of Insurance Benefits: I hereby authorize and assign, my insurance carrier(s), to make payment directly to Drs. HBR of insurance benefits for services herein specified and otherwise payable to the insured. Drs. HBR files both primary and secondary insurance as a courtesy to patients for the companies with which we participate. I understand and agree that I am financially responsible to Drs. HBR for all charges incurred regardless of potential insurance benefits including but not limited to co-payments, deductibles, and non-covered services. I understand Drs. HBR will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

Minor Patients: Any patient under the age of 18 should be accompanied by a parent/guardian. I understand by signing HBR's financial policy, I am solely responsible for any incurred charges for the below named patient. The parent who brings the child in for care is ultimately responsible for their bill and we will not get involved in support disputes.

Returned Check Fee: I understand that, if Drs. HBR receives a returned check, I will be charged $30 plus the amount on the check and I will be on a cash-only basis thereafter.

Non-Payment: We reserve the right to send an account to collection if not paid in full. If Drs. HBR refers your account over to a collection agency you will be responsible for your balance plus the collection agency fee of 25%.

1. _____ **Notice of Privacy Practices:** I acknowledge that I have reviewed a copy of Drs. HBR's Notice of Privacy Practices.
2. _____ **Medicare General Rules:** Our office is a participating provider for Medicare. Medicare requires that you pay the annual deductible toward any qualified services before Medicare will pay for any services. Our doctors accept assignment on your bill and we will file, via electronic transmission or paper claim, directly to Medicare. You will be responsible for any remaining amount they do not pay. As a courtesy to you, we will file any supplemental insurance.

   Special Exceptions
   a. Medicare does not cover eyeglasses or contact lenses unless you have had cataract surgery.
   b. Medicare does not cover the refraction part of the eye exam. Our fee for this is $55.
   c. Medicare does not cover any services without a medical diagnosis. The need for glasses is not considered a medical diagnosis.
3. _____ **Kansas Medicaid Advanced Beneficiary Notice:** This constitutes Notice to you, the beneficiary, that if Drs. HBR meets all program requirements and payment is not made by KanCare, you may be held responsible for the charges if your services or materials are not covered by KanCare. This includes but is not limited to the eye exam, frame, lenses, coatings, or medically necessary contacts. *CONTACTS AND CONTACT LENS SERVICES ARE NOT A COVERED BENEFIT OF KANCARE (except United Healthcare KanCare).*

Patient's signature (Parent if minor): _____ Date: _____

Disclosures to Friends and/or Family Members
If a designated a family member or other individual may discuss your medical conditions with the doctor, please list below.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Drs. Hawks, Besler & Rogers
OPTOMETRISTS
Terry F. Hawks, O.D. **L. Gregory Besler**, O.D. **Jason B. Rogers**, O.D. **Jon B. Stoppel**, O.D.

Date:_____

HEALTH SCREENING PHOTOS

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

WHAT ARE EYE HEALTH SCREENING PHOTOS?

This is one of the newest technologies for helping doctors manage the health of the eye. High Definition retinal photography allows us to examine, evaluate, and document the retina and the optic nerve.

The retina is the tissue in the back of the eye that is responsible for vision and the optic nerve is the structure that is responsible for transmitting the visual information from the retina to the brain.

WHAT THINGS CAN YOU SEE WITH RETINAL PHOTOGRAPHY?

Retinal photography is extremely useful in detecting eye diseases such as glaucoma, macular degeneration, and retinal disorders, as well as detecting signs of systemic diseases like diabetes and hypertension (high blood pressure).

WHO NEEDS THIS TEST?

Even though many of these eye conditions affect adults, retinal screening photography is recommended for all patients, including children. Retinal photos are helpful in identifying past eye injuries and provide a baseline for monitoring changes in or progression of future eye disorders.

HOW DOES RETINAL PHOTOGRAPHY WORK?

Retinal photography is easy, comfortable , and takes only a few minutes. Most images can be captured without using dilating drops and can be viewed immediately by the doctor and patient.

Retinal images are stored digitally and are kept as part of your record. The images can be compared year after year at your annual eye examination.

HOW MUCH DOES IT COST?

The fee is $34.00 for both eyes.

EARLY DETECTION AND TREATMENT OF EYE DISEASE IS CRITICAL IN PRESERVING VISION FOR A LIFETIME!

☐ Yes, I choose to have this test performed at this time.

☐ No, I choose to defer this test at this time.

☐ I prefer to discuss with the Doctor prior to the test.

Patient's signature: _____ Date: _____
(parental signature needed if under age of 18)