

OFFICE: FLAM CHEY
 DATE: _____

NEVADA EYE CARE PROFESSIONALS

CHART #: _____

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	
PATIENT'S ADDRESS	APT. OR SPACE #	CITY	STATE	ZIP CODE
DATE OF BIRTH	AGE	MARITAL STATUS	SEX	EMAIL ADDRESS
HOME PHONE				
PATIENT'S EMPLOYER	OCCUPATION			WORK PHONE
EMPLOYER'S ADDRESS	SUITE #	CITY	STATE	ZIP CODE

SPOUSE OR PARENT INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	
ADDRESS	APT. OR SPACE #	CITY	STATE	ZIP CODE
RELATIONSHIP TO PATIENT	DATE OF BIRTH			HOME PHONE
EMPLOYER	OCCUPATION			WORK PHONE
EMPLOYER'S ADDRESS	SUITE #	CITY	STATE	ZIP CODE

INSURANCE INFORMATION (Please let us copy your insurance cards.)

PRIMARY INSURANCE COMPANY NAME	POLICY #	GROUP #	INSURANCE CO. PHONE #
NAME OF INSURED	RELATIONSHIP TO PATIENT		PHONE # OF INSURED
EMPLOYER OF INSURED	SOCIAL SECURITY # OF INSURED		BIRTHDATE OF INSURED
SECONDARY INSURANCE COMPANY NAME	POLICY #	GROUP #	INSURANCE CO. PHONE #
NAME OF INSURED	RELATIONSHIP TO PATIENT		PHONE # OF INSURED
EMPLOYER OF INSURED	SOCIAL SECURITY # OF INSURED		BIRTHDATE OF INSURED

IS THIS A WORK RELATED INJURY? YES NO (CIRCLE ONE)

PLEASE HELP US GET TO KNOW YOU BETTER . . .

WHAT BRINGS YOU TO OUR OFFICE? _____

PLEASE CHECK THE CONDITIONS THAT YOU EXPERIENCE (✓)

<u>EYE PROBLEMS</u>	LEFT EYE	RIGHT EYE	HOW LONG?	<u>OTHER PROBLEMS</u>
REDNESS	<input type="checkbox"/>	<input type="checkbox"/>	_____	SINUS CONGESTION <input type="checkbox"/>
DRY EYE FEELING	<input type="checkbox"/>	<input type="checkbox"/>	_____	NASAL CONGESTION <input type="checkbox"/>
MUCOUS DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	_____	POST-NASAL DRIP <input type="checkbox"/>
SANDY OR GRITTY FEELING	<input type="checkbox"/>	<input type="checkbox"/>	_____	CHRONIC COUGH <input type="checkbox"/>
ITCHING	<input type="checkbox"/>	<input type="checkbox"/>	_____	BRONCHITIS <input type="checkbox"/>
BURNING	<input type="checkbox"/>	<input type="checkbox"/>	_____	ASTHMA SYMPTOMS <input type="checkbox"/>
FOREIGN BODY SENSATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALLERGY SYMPTOMS <input type="checkbox"/>
CONSTANT TEARING	<input type="checkbox"/>	<input type="checkbox"/>	_____	SEASONAL ALLERGY <input type="checkbox"/>
OCCASIONAL TEARING	<input type="checkbox"/>	<input type="checkbox"/>	_____	HAY FEVER <input type="checkbox"/>
WATERY EYES	<input type="checkbox"/>	<input type="checkbox"/>	_____	COLD SYMPTOMS <input type="checkbox"/>
LIGHT SENSITIVITY	<input type="checkbox"/>	<input type="checkbox"/>	_____	EAR CONGESTION <input type="checkbox"/>
EYE PAIN OR SORENESS	<input type="checkbox"/>	<input type="checkbox"/>	_____	SNEEZING <input type="checkbox"/>
CHRONIC EYE INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____	DRY THROAT/MOUTH <input type="checkbox"/>
STIES OR CHALAZION	<input type="checkbox"/>	<input type="checkbox"/>	_____	HEADACHES <input type="checkbox"/>
FLUCTUATING VISION	<input type="checkbox"/>	<input type="checkbox"/>	_____	ARTHRITIS <input type="checkbox"/>
"TIRED" EYES	<input type="checkbox"/>	<input type="checkbox"/>	_____	JOINT PAIN <input type="checkbox"/>

OTHER PROBLEMS: _____

<u>PAST EYE/MEDICAL HISTORY</u>	YES	NO	IF YES, PLEASE GIVE DETAILS BELOW
DO YOU USE LUBRICATING EYE DROPS?	<input type="checkbox"/>	<input type="checkbox"/>	WHAT BRAND? _____
DO YOU WEAR GLASSES?	<input type="checkbox"/>	<input type="checkbox"/>	FOR NEAR? _____ FOR FAR? _____
HAVE YOU EVER HAD AN EYE INJURY?	<input type="checkbox"/>	<input type="checkbox"/>	DESCRIBE: _____
HAVE YOU EVER HAD AN EYE SURGERY?	<input type="checkbox"/>	<input type="checkbox"/>	DESCRIBE: _____
DO YOU USE CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	WHAT BRAND? _____
			ARE THEY COMFORTABLE? _____
ARE YOU ALLERGIC TO ANYTHING?	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE LIST: _____

DO YOU TAKE ANY MEDICATIONS?	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE LIST: _____
------------------------------	--------------------------	--------------------------	--------------------

ARE YOUR EYES SENSITIVE TO? (PLEASE CIRCLE ALL THAT APPLY):

HEATERS, BLOWERS, AIR CONDITIONING, CIGARETTE SMOKE, SMOG, DUST, POLLEN, WIND,
VIDEO DISPLAY TERMINALS, SUNSHINE, CONTACT LENSES OR SOLUTIONS, EYE DROPS

WE WELCOME YOU AS A NEW PATIENT. WHO OR WHAT TOLD YOU ABOUT US? PLEASE FILL-IN OR CHECK (✓).

DOCTOR (NAME) _____ INSURANCE CO. (NAME) _____

CLINIC/HOSPITAL (NAME) _____ YELLOW PAGES _____

A PATIENT OF OURS (NAME) _____ BUILDING SIGN _____

A FRIEND OR FAMILY MEMBER (NAME) _____ NEWSPAPER ARTICLE _____

LECTURE OR SEMINAR _____ NEWSPAPER AD _____ WEB SITE _____ OTHER _____

PATIENT-PHYSICIAN AGREEMENT

- ◆ I REQUEST THAT NEVADA EYE CARE PROFESSIONALS AND/OR ITS ASSOCIATED DOCTORS PROVIDE PROFESSIONAL SERVICES FOR WHICH I WILL IMMEDIATELY PAY ALL INCURRED CHARGES IF THEY ARE NOT OTHERWISE PAYABLE AND PAID BY MY INSURANCE COMPANY, EMPLOYER, OR MANAGED CARE ORGANIZATION (IF ANY) WITHIN 60 DAYS, FOR ANY REASON, UNLESS PROHIBITED BY CONTRACT OR LAW.
- ◆ I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION PERTAINING TO THE CARE OF THE PATIENT NAMED ON THE REVERSE OF THIS PAGE TO HEALTH CARE PROVIDERS OR PAYORS OF THE CHARGES ASSOCIATED WITH THE CARE OF SAID PATIENT.
- ◆ I AUTHORIZE NEVADA EYE CARE PROFESSIONALS AND/OR ITS ASSOCIATED DOCTORS TO RELEASE ANY INFORMATION TO PROCESS MY HEALTH BENEFITS/INSURANCE CLAIM(S) AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO NECP FOR SERVICES RENDERED.
- ◆ ACCOUNT REFUNDS OF \$5.00 OR LESS WILL NOT ISSUED DUE TO HANDLING EXPENSES.
- ◆ IF MY ACCOUNT IS SENT TO COLLECTIONS, A \$30.00 CHARGE OR 10% OF THE OUTSTANDING BALANCE (WHICHEVER IS GREATER) WILL BE ADDED TO THE ACCOUNT BALANCE.
- ◆ A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND AGREE WITH THE ABOVE TERMS.

SIGNATURE: _____ DATE: _____

EMERGENCY CONTACT PERSON (Someone Not Living with You)

NAME _____ RELATIONSHIP _____ PHONE _____

NEVADA EYE CARE PROFESSIONALS

2080 East Flamingo Road, Suite 500, Las Vegas, Nevada 89119
7730 West Cheyenne Ave., Suite 103, Las Vegas, Nevada 89129

www.nevadaeyecare.com

PHONE: (702) 733-9271

FAX: (702) 733-1556



OPHTHALMOLOGY - OPHTHALMIC SURGERY - OPTICAL SERVICES

LOREN E. LITTLE, M.D., F.A.C.S.

PAUL CASEY, M.D.

EMIL A. STEIN, M.D., F.A.C.S.

STEWART D. PARK, M.D.

Consent For Treatment, Payment, and/or Healthcare Operations

The undersigned acknowledges and permits Nevada Eye Care Professionals to use and disclose Personal Health Information to carry out treatment, payment, and/or healthcare operations. Further, the undersigned acknowledges receipt of Nevada Eye Care Professionals' Notice of Privacy Practices which details permitted uses and disclosures of information.

The undersigned understands that the Notice of Privacy Practices may, from time to time, be amended or changed. Patients (individuals) will be notified of any changes that might affect them prior to application of those changes to their Personal Health Information. Notice will be provided to them, in person, at our offices or delivered to the last known address of the patient as provided to Nevada Eye Care Professionals.

Patients (individuals) have a right to request that Nevada Eye Care Professionals restrict how his or her Personal Health Information is used or disclosed to carry out treatment, payment, and/or healthcare operations. Nevada Eye Care Professionals is not required to agree with such a request, but if Nevada Eye Care Professionals agrees to the request, Nevada Eye Care Professionals will be bound by that request.

Patients (individuals) have the right to revoke this consent by writing to the Privacy Officer at Nevada Eye Care Professionals. If Nevada Eye Care Professionals has already used or disclosed information in reliance on the consent, such a revocation will have effect only on future use or disclosure--after it has been received by the Privacy Officer at Nevada Eye Care Professionals.

Signature of Patient

Date (month/day/year)

Signature of Authorized Representative

Authority to Act for Patient

NEVADA EYE CARE PROFESSIONALS

2080 East Flamingo Road, Suite 500, Las Vegas, Nevada 89119
7730 West Cheyenne Ave., Suite 103, Las Vegas, Nevada 89129

www.nevadaeyecare.com

PHONE: (702) 733-9271

FAX: (702) 733-1556



OPHTHALMOLOGY - OPTHALMIC SURGERY - OPTICAL SERVICES

LOREN E. LITTLE, M.D., F.A.C.S.

PAUL CASEY, M.D.

EMIL A. STEIN, M.D., F.A.C.S.

STEWART D. PARK, M.D.

AUTHORIZATION – GENERAL PURPOSE REQUESTED BY PATIENT

The undersigned authorizes the use and disclosure of the following Personal Health Information: Medical, Billing, and Personal Identifying Information (UNLESS CROSSED OUT) to the following: Health Care Providers and Health Benefits-Insurance-Payment Entities (UNLESS CROSSED OUT) by Nevada Eye Care Professionals. This authorization is valid indefinitely UNLESS AN EXPIRATION DATE IS FILLED IN HERE _____.

The undersigned has a right to revoke this authorization in writing, unless revocation is precluded by law, by written request to the Privacy Officer at Nevada Eye Care Professionals. The information used or disclosed may be subject to redisclosure by the recipient and thereby no longer protected by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996. The undersigned has the right to refuse to sign this authorization and no treatment, payment, enrollment, or eligibility will be conditioned upon obtaining this authorization.

Signature of Patient

Date (month/day/year)

Signature of Authorized Representative

Authority to Act for Patient