Nancy A Houlder, MD
Eye Physician and Surgeon
CONFIDENTIAL INFORMATION FORM

Dr. Houlder performs ***LASER VISION CORRECTION SURGERY***. Are you interested in this procedure? _____

Name of Patient: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ Cell Phone: _____ Birth Date:_____

Social Security #: _____ Gender: _____ Marital Status: _____

E-mail Address: _____ ☐ I give permission to receive emails.

Name of Employer: _____ Work Phone: _____ Employment Status: _____

Address of Employer: _____
(Street) (City) (State) (Zip Code)

Spouse's Name: _____
(Last) (First) (Middle)

Primary Care Physician: _____Who referred you to our office? _____

Emergency contact: _____
(Last) (First) (Phone #)

********** **Insurance Information** **********

Primary Insurance	Secondary Insurance
Carrier Name: _____	Carrier Name: _____

Subscriber Name: _____
(Last) (First) (Middle)

Subscriber Address: _____
(Street) (City) (State) (Zip Code)

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Subscriber Gender: _____ Relationship to Patient: _____ Subscriber Employer: _____

Do you have Routine Eye Insurance Yes No Carrier Name: _____

Do you have a Health Savings Account or Flexible Spending Account? Yes No

**********Dilated Pupil Examination**********

Our standard examination includes dilating your pupils when indicated. There is no additional charge for this procedure. Dilation is especially indicated for patients with a family history of eye disease such as glaucoma, retinal detachment, etc., or health problems such as diabetes, high blood pressure, etc. The recent onset of visual symptoms such as floaters, flashes of light, unusually blurred vision, headaches. etc. almost always require dilation in order to properly diagnose the cause. Dilation generally lasts a few hours and during that time your near vision will be somewhat blurred. You will also be more sensitive to light. However, you should still be able to drive and continue your day-to-day activities without difficulty. Sunglasses will be provided for your convenience. If there is some reason you feel you should not have your pupils dilated today, please discuss this with the doctor.

Signature required: _____ Date: _____

PLEASE TURN OVER SIDE ONE OF TWO

FINANCIAL INFORMATION

We want to provide you with the very best service possible. We will be happy to assist you with any questions or concerns that you have regarding the services rendered.

1. Contact lenses are medical devices and require additional testing beyond what is performed during a routine eye exam. Contact lens exams have a separate charge and are not included in the regular exam fee. There is a $25.00 yearly fitting and evaluation fee for established contact lens patients. The initial fitting and teaching fee is $70.00. There are additional charges if there is a difficult fit or for a toric or bifocal lens. The fitting and evaluation fee is required prior to receiving a contact lens prescription and trial lenses.

2. Please provide your driver's license and current health insurance card at the time of your appointment.

3. Routine eye exams cover checking the prescription for glasses and screening for medical problems. Routine eye exams do not cover discussion and treatment of medical problems. Health care insurances such as Cigna, Medicare, Aetna, Blue Cross and Blue Shield, Rocky Mountain Health Plans, PacifiCare, Secure Horizons, and Great West cover exams for medical problems of the eye. Medical problems include dry eyes, allergies, blurry vision, cataracts, diabetic exams, glaucoma, macular degeneration, floaters, and infections. An exam for the discussion and treatment of medical problems will be billed to your medical insurance.

4. I authorize insurance payments of medical benefits to Nancy A. Houlder, MD and West Denver Optical for all services. I authorize the release of medical or other information necessary to process this claim. I authorize the release of medical or other information to other health care providers when requested. I also request payment of government benefits to Nancy A. Houlder, MD on my behalf. Patients will be responsible for all charges not covered by their insurance company. It is the patient's responsibility to give us the current insurance information on the date of service. We will use the insurance information that you give us when the exam is scheduled. We will not be able to change the insurance billed after services are rendered. In the event that the bill should go to collections, the patient is responsible for the collection agency and attorneys' fees. A 1.5% financing fee is charged per month on balances due. There is a $ 25.00 charge if copay is not paid on date of service.

Signature required _____ Date _____

Name_____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / **LYMPH** (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / **IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion? **.....YES NO**
Do you drink alcohol?**.....YES NO** If YES, how much? _____
Do you smoke? **.....YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

PLEASE TURN OVER SIDE ONE OF TWO

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Nancy A. Houlder, MD Privacy Practices with the effective date of April 14, 2003.

I authorize Nancy A. Houlder, MD to release medical records or medical information to the following person(s):

(Last)	(First)	(Relationship to patient)
(Last)	(First)	(Relationship to patient)
(Last)	(First)	(Relationship to patient)

_____ _____

Signature of Patient/ Patient Representative **Date**

_____

Relationship to patient