Northwest Eye Center
4855 Ward Rd Suite 500
Wheat Ridge, CO 80033
Phone: (303)467-0500
Fax: (303)467-0502
info@northwest-eye.com

Northwest Eye Center, P.C.

Patient Registration

Patient Name				**Salutation (Circle One)**	Mr. Ms. Miss. Mrs. Dr.
Date of Birth		**Age**		**SS #**	
Sex					
Address					

Communication			
Preference	**Circle One:** Home Cell Work		
Home Phone #		**Work Phone #**	
Cell Phone #			
Email			

Information			
Primary Language		**Race**	
Marital Status			

Account Responsible (If Different From Above)			
Responsible		**DOB**	
Relationship		**Phone**	
Address			

Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			

Other / Secondary Insurance			
Name		**Group Name**	
ID #		**Group #**	

Emergency Contact			
First	**Last**	**Relation**	**Phone#**

PCP and Other Physicians			
First	**Last**	**Specialty**	**Location (City, State)**

How Did You Hear About Us (Circle All That Apply)?		
Advertisement	Family:_____	Friend:_____
I am a Previous Patient	Other:_____	Referral:_____
Search Engine:_____	Social Media: Yelp, Facebook	Website:_____

Northwest Eye Center, P.C.

Melinda C. O'Rourke, M.D.
Nolan P. Hathaway, M.D.
Eye Physicians & Surgeons
4855 Ward Rd #500
Wheat Ridge, CO 80033
Ph: 303.467.0500 Fx: 303.467.0502

Name:_____ **Date:**_____

Reason for todays visit:_____ **Last Eye Exam:**_____**Previous Eye Dr:**_____

Do you have or have you ever been treated for: If none apply , please check here ☐

		If yes, please add year of diagnosis.	*Year*				*Year*
Y	N	**Glasses** *Distance ☐ Reading ☐ Both ☐*		Y	N	**Eye Surgery** *type?*	
Y	N	**Contacts** *Soft ☐ RGP ☐ Monovision ☐ Brand ?* _____		Y	N	**Eye Trauma** *type?*	
Y	N	**Amblyopia/Strabismus** "Lazy eye"		Y	N	**Floaters/Spots**	
Y	N	**Blepharitis**		Y	N	**Glaucoma**	
Y	N	**Cataract**		Y	N	**Inflammation** *Iritis ☐ Uveitis ☐*	
Y	N	**Corneal Disease**		Y	N	**Lasik ☐ PRK ☐ RK ☐**	
Y	N	**Diabetic Retinopathy**		Y	N	**Macular Degeneration** *Dry ☐ Wet ☐*	
Y	N	**Double Vision**		Y	N	**Macular** *Hole ☐ Pucker ☐*	
Y	N	**Droopy Eyelids**		Y	N	**Retinal** *Detachment ☐ Tear ☐*	
Y	N	**Dry Eyes** *plugs ☐ drops ☐*				**Other** _____	
Y	N	**Eye Infection** *type?*				**Other** _____	

Medical History

Do you have or have you ever been treated for: *check all that apply. If none apply , please check here ☐*

☐**Allergeries** *(environmental,seasonal)*	☐**Diabetes** *Type 1 ☐ Type 2☐*	☐**Lupus**
☐**Anxiety/Depression**	*If diabetic, last A1c* _____*BS*_____	☐**Mental Disorder** *type?*
☐**Asthma**	☐**Graves Disease**	☐**Migraines/Headaches**
☐**Atrial Fibrillation**	☐**GERD**	☐**Multiple Sclerosis**
☐**Cancer** *type?*	☐**Hearing Loss**	☐**Osteoporosis**
☐**Congestive Heart Failure**	☐**High Blood Pressure** *last BP* _____	☐**Pacemaker** ☐**Stent**
☐**COPD**	☐**High Cholesterol**	☐**Rheumatoid Arthritis**
☐**CVA***(stroke)*	☐**Hypothyroidism**	☐**Sjogren's Syndrome**
☐**Dementia/Alzheimer**	☐**Kidney Disease**	☐***Other***_____

Family History

Do any of the following medical or eye diseases run in your family: *Check all that apply. If none apply , please check here ☐*

☐**Amblyopia/Strabismus** *"Lazy eye"*	☐**Diabetes**	☐**High Cholesterol**
☐**Blindness**	☐**Diabetic Retinopathy**	☐**Macular Degeneration (Dry/Wet)**
☐**Cancer** *type?*	☐**Dry Eyes**	☐**Retinal Detachment/Tear**
☐**Cataracts**	☐**Glaucoma**	☐**Rheumatoid Arthritis**
☐**Corneal Disease/Dystrophy**	☐**Heart Disease**	☐**Sjogren's Syndrome**
☐**CVA(stroke)**	☐**High Blood Pressure**	☐***Other***_____

Medications Yes ☐ No ☐ *If yes, please list below name, dosage, frequency. Have a list ? We'd be happy to copy it.*

Allergies to Medications Yes ☐ *if yes please list below* **No ☐**

Smoker Non☐ Current☐ Former☐ *Year Quit* _____

I have completed this medical history to the best of my knowledge. *(please sign)*_____

Authorization for Release of Medical Information to a Family Member, Friend, or Designated Legal Representative

It is the responsibility of **Northwest Eye Center** to ensure that information regarding patients remains confidential. This means that information regarding your medical condition, billing and insurance issues, or any other protected health information as identified under HIPAA, cannot be released to other people, not even family members. You may authorize, in writing, the person(s) to whom you want the information released. Your patient confidentiality rights are protected under the Colorado State Public Health Law.

We realize that there are times when you, the patient, may want other people to be knowledgeable about your medical condition or other issues. To do this, you must complete the form listed below. Please note the following:

- Only 2 people can be designated for this role
- The authorization is valid until you cancel it in writing
- If you designate no one, **Northwest Eye Center** cannot release information to any family member or friend

Authorization:

I, (Print Name) _____, Date of Birth _____, designate the following person(s) to be able to speak with staff at **Northwest Eye Center** on my behalf about my medical condition or the status of my account. I release **Northwest Eye Center** and its staff from any claim of confidentiality in connection with release of this information.

Name of Designated Person: _____

Relationship: _____Phone Number: _____

☐ (check box if applicable) **Power of Attorney**: necessary paperwork will be provided to Northwest Eye Center

Name of Designated Person: _____

Relationship: _____Phone Number: _____

☐ (check box if applicable) Power of Attorney: necessary paperwork will be provided to Northwest Eye Center

☐ **I *do not wish* to designate anyone at this time.**

_____ _____

Patient Signature Date

Northwest Eye Center P.C.
Financial Policy & HIPAA

Welcome to Northwest Eye Center. In order for us to be able to deliver the quality of care that you are accustomed to, we have established certain financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible. Please read all the information and acknowledge by signing below.

1. Insurance Coverage: I acknowledge that the insurance cards I have presented are current and accurate. **I will notify the front desk of any personal demographic or insurance changes.**
2. Co-pays & out of pocket: All co-pays, non-covered procedures, or deductible amounts are due at the time of service. After your insurance company has processed your claim, if there is any balance due, we will send a statement to your home address. Balance is due upon receipt of statement.
3. Self-Pay Patient: Patients with no insurance will be expected to pay for all services, at the time of service.
4. Vision Plans: Northwest Eye Center participates in a very limited number of vision plans. **It is your responsibility to know which plans are accepted, and if your plan is covered. You must present your routine vision insurance information before services are rendered. If you do not have routine vision benefits and do not have a medical complaint at the time of service you may be responsible for charges at time of service.**
5. Billing Insurances: It is patient responsibility to know whether your medical insurance covers a routine eye exam every year. Northwest Eye Center cannot reprocess the claim if this information was not obtained before your visit.
6. **Refractions: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contacts. Medicare and most medical insurance companies do not cover the fee for refractions. The patient is responsible for a $35.00 refraction fee at the time of service. If it is billed to insurance and not covered the patient will be billed the full insurance amount of $57.00**
7. **Contact Lenses: There is an additional fitting fee for contact lens wearing patients. For a new wearer there is a fee of $80.00. For an existing wearer, there is a fee of $45.00.**
8. No show/cancelled/rescheduled appointments: We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a 24 hour cancelation. **More than three of these appointments in a row is subject to a $25.00 charge.**
9. Release of information: I authorize my physician to release (verbally or in writing) confidential medical information contained in my medical record to any person or entity which may be liable to me or my physician for charges or this treatment and/or quality management/utilization, review, transfer and follow up purposes. I am aware of the availability of the protected health information for the Northwest Eye Center and their office policies for handling all such information and indicate that I was notified of the copy available in the office.
10. Contents and Disclosures: I hereby voluntarily agree to diagnostic procedures, medical and surgical treatment which may be administered to or performed on me under general or special instructions or the attending practitioner's care and service of the practitioner's designee. I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk. No guarantees have been made to me as the results of my treatment by Northwest Eye Center. I understand that Northwest Eye Center encourages me to ask questions and voice any and all concerns about medical care and services and in doing so will not compromise my care.
    Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department.

    I have read and have a full understanding of the financial policy and HIPAA agreement of Northwest Eye Center.

Signature: _____ Relationship to patient:_____ Date: _____

Northwest Eye Center, P.C. essence LASER & WELLNESS

QUESTIONNAIRE

Thank you very much for your time. We value your opinion, and your feedback helps us to know what to offer our valued patients next door at **Essence**, our **Laser and Wellness Center**.

Would you like to schedule a complimentary mini-facial with us?

Yes__ No__

Would you like to decrease the excess skin on the upper eyelids and/or baggy puffy skin on the lower eyelids?

Yes__ No__

Would you like information on treatments for age spots, wrinkles, and other signs of aging?

Yes__ No__

Are you interested in knowing more about laser hair reduction, and reduction of vellus facial hair?

Yes__ No__

Would you like to schedule a complimentary consultation regarding skin care products, as well as treatments to maintain and restore healthy skin?

Yes__ No__

Name_____ Phone_____

E-Mail_____ Best time to reach you_____

Any other suggestions you would like us to offer?_____

_____