OASIS EYE CARE

TRENITY S. McKINNEY, M.D.
1868 S. Tamiami Trail
Venice, FL 34293
941-493-9393

Appointment date:_____

Patient Name:_____Nickname:_____

Address:_____

_____

Home phone:_____Cell phone:_____

Date of Birth:_____Social Security #:_____

Emergency Contact:_____Phone number:_____

Primary Physician:_____

Who referred you to our office:_____

What months are spent in Florida:_____

Northern address:_____

Northern phone number:_____

Preferred pharmacy_____

Email:_____

Note: A $25 fee will be assessed for appointments that are missed/cancelled without a 24 hour notice.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relies on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our policy notice.

Patient Name: _____

Signature: _____

Date: _____

COMPLETE REVERSE SIDE

OASIS EYE CARE
PATIENT HISTORY AND HEALTH QUESTIONNAIRE FORM

Welcome to our office! In order that we may meet your eye care needs, we need to become familiar with you and your health care needs. Please help us by filling out the entire health questionnaire both sides entirely. The doctor or technician will review this form with you once it has been completed.

Name: _____ Age: _____ Date: _____

Date of Birth: _____ Who referred you here:_____

Family Medical Doctor: _____Endocrinologist_____

Cardiologist: _____Reason for visit:_____

Do you have any **allergies to medications**? (Circle one) **YES** or **NO** (If yes, please list below.)

_____ _____ _____ _____

Ocular History: Please **circle** any eye conditions that apply to you

Cataracts	Glaucoma	Macular Degeneration	Amblyopia/Lazy eye	Dry Eyes

Have you ever had **EYE SURGERY** or an **EYE INJURY**? (**Circle** one) **NO** or **YES** (If YES, list below)

Year	Which Eye	Type of Surgery/Injury

Are you using **eye drops**? (Circle one) **Yes** or **NO** (If yes, please list below.)

_____ _____ _____ _____

Medical History: Please **circle** the conditions that apply to you with the **year** diagnosed on the line.

Allergies (seasonal)	Diabetes -_____	Kidney Disease	Shingles/Zoster
Anemia	Emphysema (COPD)	Lupus	Sinusitis
Arthritis	Gastric Reflux	Macular Degeneration	Sjögren's disease
Asthma	Heart Attack	Migraines	Stroke - _____
Cancer - _____	Heart Disease	Parkinson's	Thyroid - _____
Cataracts -_____	High Blood Pressure	Prostate Problems	TIA's - _____
Chronic Bronchitis	High Cholesterol	Seizures	Others? State on back

Additional Medical History : _____

_____

Surgical History: List all **major surgeries** other than eye surgery.
(Example: gallbladder, hernia, C-section, appendix..)

Year	Type of Surgery

Are you taking any **oral medications** (pills)? (Circle one) **YES** or **NO** (If yes, please list below.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family History: Do any of these conditions run in the family? **Circle** either **Y** or **N** for each question. (**If YES**, please tell us which family member had this condition on the lines provided below.)

Diabetes	Y or N	Kidney Disease	Y or N	Retinal Disease	Y or N
Cancer	Y or N	Blindness	Y or N	High Blood Pressure	Y or N
Heart Disease	Y or N	Cataracts	Y or N	Arthritis	Y or N
Stroke	Y or N	Glaucoma	Y or N	Lazy Eye	Y or N
TB	Y or N	Macular Degeneration	Y or N	Other:	

Social History: Circle one for each question.

Do you smoke currently? Y or N Did you smoke in the past? Y or N What year did you quit?	Do you drink alcohol? Y or N Circle those that apply: WINE BEER LIQUOR Drinks per week:
Support System: Married Widow Single Assisted Living Nursing Home	Do you currently work? Y or N Occupation:
Have you ever used drugs? Y or N Drugs used:_____How long:_____ What year did you quit?_____	

Have you ever taken **steroid eye drops or pills**? (Circle) **YES** or **NO** (If yes, state type and when.)

_____

Tech initials_____ Physician initials_____

Review of Systems **Patient Name:_____**

Eyes		**Respiratory**		**Blood/Lymphnodes**	
Previous Surgery	Y or N	Cough	Y or N	Easy Bruising	Y or N
Contact Lenses		Congestion	Y or N	Gums Bleed Easily	Y or N
Do you wear?	Y or N	Wheezing	Y or N	Prolonged Bleeding	Y or N
Pain	Y or N	Asthma	Y or N	Aspirin Use	Y or N
Double vision	Y or N				
Glaucoma	Y or N				
Cataracts	Y or N	**Gastrointestinal**		**Musculoskeletal**	
Macular Degeneration	Y or N	Heartburn	Y or N	Stiffness	Y or N
Dry Eyes	Y or N	Nausea/Vomiting	Y or N	Arthritis	Y or N
Flashes or Floaters	Y or N	Jaundice/Hepatitis	Y or N	Joint Pain/Swelling	Y or N
Endocrine		**Genito-Urinary**		**Skin**	
Diabetes Years:_____	Y or N	Pain/Difficulty	Y or N	Rash/Sores	Y or N
Thyroid Disease	Y or N	Blood in Urine	Y or N	Lesions	Y or N
Increased thirst or Hunger	Y or N	Hx of Kidney Stones	Y or N	Hives/Eczema	Y or N
Increased Urination or Sweating	Y or N	Hx of STDs	Y or N	Skin Cancer	Y or N
Fingernail Changes	Y or N	Bladder Problems	Y or N	Basal	Y or N
		Prostate Problems	Y or N	Squamous	Y or N
Ear, Nose and Throat				Melanoma	Y or N
Hard of Hearing	Y or N			Location:_____	
Ringing in Ear	Y or N				
Vertigo	Y or N	**Psychiatric**		**Neurological**	
		Anxiety/Depression	Y or N	Seizures	Y or N
Cardiovascular		Mood Swings	Y or N	Weakness/Paralysis	Y or N
Chest Pain	Y or N	Difficulty Sleeping	Y or N	Tremors	Y or N
Dizziness or Fainting	Y or N			Alzheimer's	Y or N
Shortness of Breath	Y or N	**Immunologic**		Parkinson's	Y or N
Irregular Heartbeat	Y or N	Hives	Y or N		
Difficulty Lying Flat	Y or N	Itching	Y or N	**Constitutional**	
Hypertension	Y or N	Runny Nose	Y or N	Fatigue/Weakness	Y or N
Elevated Cholesterol	Y or N	Sinus Pressure	Y or N	Fever	Y or N
Heart Disease	Y or N			Weight Gain/Loss	Y or N
Heart Attack	Y or N				
Stroke	Y or N				

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941-493-9393
MEDICAL INFORMATION RELEASE AUTHORITY

I authorize the physician/staff of Oasis Eye Care to release/leave information pertaining to the following:

___ My medical condition and treatment

___ My finances and insurance obligations

The above information may be discussed with the following:

Name	phone number	relationship
Name	phone number	relationship
Name	phone number	relationship
Name	phone number	relationship

The above information may be left on my answering machine/voicemail. Y N

I understand that no information will be provided to family members, including spouses, unless their name(s) appear above. I also understand that this release of information will remain in effect until I provide written notification of any change.

Patient signature:_____Date:_____

CANCELLATION/NO SHOW POLICY

This office will assess a $25 fee for any appointment that is missed/cancelled without a 24 hour notice. (Exceptions will be made in the event of an emergency.) By signing below I acknowledge that I am aware of this policy and agree to its terms.

Patient signature:_____Date:_____

Witness:_____Date:_____

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION THE TO RELEASE INFORMATION

1. TREATMENT AUTHORIZATION - I, the below named patient, do hereby give TRENT S. McKINNEY M.D., consent for medical treatment.
2. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician of this group examining and/or treating me to receive to any third party payer (such as insurance company or government agency) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment or such treatment and/or diagnosis.
3. PHYSICIAN INSURANCE ASSIGNMENT -I, the below named subscriber, hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for the services.
4. MEDICARE/MEDICAID - Patients certification authorization to release information and payment requests. I certified that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act/Division of Family Services or its intermediaries or carriers of any information needed for this for a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
5. I PERMITTED A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This Assignment will remain in effect until revoked by me in writing.

Please remember that the insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. As a courtesy, our office will bill your insurance and resubmit only one time if necessary.

I UNDERSTAND IT'S MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE OR THIRD PARTY PAYER WITHIN 60 DAYS OF THE OFFICE VISIT.

I UNDERSTAND THE ABOVE AGREEMENT AND SIGN AS THE RESPOSIBLE FINANCIAL PARTY.

PATIENT'S SIGNATURE: _____

DATE: _____

MEDIGAP OR SECONDARY INSURANCE SIGNATURE

I request that payment of Medigap benefits be made on my behalf to Trent McKinney, M.D. for any services furnished to me by (physician/supplier). I authorize any holder of medical information about me to release to my insurance any information needed to determine benefits or the benefits payable for related services.

PATIENT'S SIGNATURE: _____ DATE: _____

SUBSCRIBER (if different from patient) _____

SUBSCRIBER BIRTHDATE: _____