Leslie Faulkner, O.D.
311 SE Delaware Ave
Bartlesville, Ok. 74003

Patient Information (Mr. / Mrs. / Ms.)

Name (Last, First, Middle) _____
Address: _____
City: _____State: _____Zip: _____
Phone: (H) _____ (C) _____
Date of Birth: _____/____/_____ SSN: _____
Employer: _____
Email: _____ Approve to use email: **Y** / **N**

Insurance Information

Medical Insurance

Primary Medical Ins. :_____ Secondary Medical Ins.: _____
Policy Holder: _____ Policy Holder: _____
Insured DOB: _____ Insured DOB: _____
ID#: _____ ID#: _____
Policy Holder Employer:_____ Policy Holder Employer:_____

Vision Insurance

Primary Vision Ins: _____ Secondary Vision Ins: _____
Policy Holder: _____ Policy Holder: _____
Insured DOB: _____ Insured DOB: _____
ID#: _____ ID#: _____

Please note: failure to provide correct medical or vision insurance information may result in rejected insurance claims at which time the cost of service/materials will become the responsibility of the patient.

Emergency Information

In case of an emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Financial Responsibility

I permit a copy of this authorization to be used in place of the original, and request payment of insurance payments to Leslie A. Faulkner, O.D. (EyeCare of Bartlesville). I understand and accept financial responsibility for all and any services rendered to me. I understand my insurance company will be billed as a courtesy to me and payment of any bill is my responsibility.

Signature of Patient/Parent/Guardian/Caretaker: _____ Date: _____

Notice of Privacy Practice

A summary "Notice of HIPPA Privacy Practices" that describes how my protected health information is used and disclosed has been made available to me. I understand I may request a printed complete copy of HIPPA Privacy Practices at any time.

Signature of Patient/Parent/Guardian/Caretaker: _____ Date: _____

Dilation Consent

In order to evaluate the internal health of the eye, it is necessary to enlarge the pupil using dilating drops. The effects of blurred vision and light sensitivity during dilation will last several hours. You have the right to refuse being dilated.

Consent: ☐ **Refuse:** ☐

Signature of Patient/Parent/Guardian/Caretaker: _____ Date: _____

Medical Questionnaire (Please Print)

Personal			Personal				Family			
Eye Conditions			**Medical Conditions (ROS)**			**Explain**	**Medical History**			
Cataract	**Yes**	**No**	Constitution	**Yes**	**No**		Autoimmune State	**Yes**	**No**	**Who:**
Age-related Macular Degeneration	**Yes**	**No**	Ears, nose, and throat	**Yes**	**No**		Disorder of Cardiovascular System	**Yes**	**No**	**Who:**
Glaucoma	**Yes**	**No**	Neuro	**Yes**	**No**		Cancer	**Yes**	**No**	**Who:**
Diabetes	**Yes**	**No**	Psychosis	**Yes**	**No**		Diabetes Mellitus in First Degree	**Yes**	**No**	**Who:**
Diabetic Retinopathy	**Yes**	**No**	Cardiovascular	**Yes**	**No**		Diabetes Mellitus Type1	**Yes**	**No**	**Who:**
Dry Eye	**Yes**	**No**	Respiratory	**Yes**	**No**		Diabetes Mellitus Type2	**Yes**	**No**	**Who:**
Eye Infection, Inflammation or Allergy	**Yes**	**No**	GI	**Yes**	**No**		Hypertension	**Yes**	**No**	**Who:**
Floaters and or Flashes of light	**Yes**	**No**	GU	**Yes**	**No**		Hyperthyroidism	**Yes**	**No**	**Who:**
Iritis or Uveitis	**Yes**	**No**	Musc/Skel	**Yes**	**No**		Hypothyroidism	**Yes**	**No**	**Who:**
Retina Defects or Degenerations	**Yes**	**No**	Integ	**Yes**	**No**		**Family**			
Eye concerns			Endo	**Yes**	**No**		**Ocular History**			
Redness	**Yes**	**No**	Hem/Lymph	**Yes**	**No**		Blindness of one eye (disorder)	**Yes**	**No**	**Who:**
Burning	**Yes**	**No**	Allergy/Immunization	**Yes**	**No**		Cataract	**Yes**	**No**	**Who:**
Itching	**Yes**	**No**	**Medications Allergies**				Degenerative Disorder (Macula)	**Yes**	**No**	**Who:**
Tearing	**Yes**	**No**					Glaucoma	**Yes**	**No**	**Who:**
Discharge	**Yes**	**No**					Lazy Eye	**Yes**	**No**	**Who:**
Vision Concerns							Retinal detachment	**Yes**	**No**	**Who:**
Blurred Vision	**Yes**	**No**					**General Personal**			
Eyestrain	**Yes**	**No**					Primary Physician			
Eye Pain	**Yes**	**No**					Do you have any other health issue	**Yes**	**No**	
Light Sensitivity	**Yes**	**No**					Height: Weight:			
Headache	**Yes**	**No**	**Other Allergies**				Do you wear glasses	**Yes**	**No**	
Poor Night Vision	**Yes**	**No**					Do you wear contacts	**Yes**	**No**	**Brand:**
Bothersome night glare	**Yes**	**No**					Do you use a computer	**Yes**	**No**	**Hours:**
Double Vision	**Yes**	**No**					Do you use multiple screens	**Yes**	**No**	
Total Loss of Vision	**Yes**	**No**					Occupation			
Social History (under PFSH)							Hobbies			
Smoke	**Yes**	**No**					Hobbies that require safety eyewea			
Amount							**Additional Comments:**			
Drink	**Yes**	**No**								
Amount										

Past Ocular History	**Medications list and Dose (***include over the counter***)**			