



# Heritage Vision Center

2427 Heritage Village, Ste 4  
Snellville, GA 30078

[www.heritagevisioncenter.com](http://www.heritagevisioncenter.com)

770 978-2020 Phone

770 978-1750 Fax

Dr. Jeffrey S. Hackleman, O.D.  
& Associates

Salutation:  Mr.  Mrs.  Miss  Ms.  Dr. Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Sex  M  F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

In case of an emergency, whom should we contact? \_\_\_\_\_

Emergency contact Phone number: \_\_\_\_\_ Relation: \_\_\_\_\_

## **How did you hear about us?**

Doctor Referral (name) \_\_\_\_\_

Heritage Vision Patient Referral (name) \_\_\_\_\_

Internet  Yellow Pages  Insurance  Other \_\_\_\_\_

# MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_ **Last eye Exam:** \_\_\_\_\_

Primary reason for today's visit (chief complaint): \_\_\_\_\_

Current Vision Problems: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Major illness or injury:	Current medications?	How Long?	Surgeries

Drug Allergies? Please list drug and reaction:  
 \_\_\_\_\_  
 \_\_\_\_\_

Circle all that apply:

Current Eye Symptoms	Review of Symptoms	Family History/ Relationship
Amblyopia (lazy eye)	Drooping eyelid	Fever
Burning	Redness	Weight loss
Cataract	Sandy or gritty feeling	Other constitutional problems
Color Blindness	Crossed eyes	Ear, nose, throat
Dryness	Blurred distance vision	Cardiovascular
Excess tearing/watering	Blurred near vision	Respiratory
Eye pain/soreness	Distorted vision (halos)	Gastrointestinal
Foreign body sensation	Double vision	Genital, kidney, bladder
Glare/Light Sensitive	Floaters or spots	Muscles, bones, joints
Glaucoma	Fluctuation vision	Skin problems
Headaches	Loss of vision	Neurological
Infection of eye or lid	Loss of side vision	Psychiatric problems
Itching		Endocrine
Macular Degeneration		Blood/lymph
Mucous discharge		Allergic/immunologic
Retinal Detachment		Pregnant/nursing
Tired Eyes		

**Social History**

Current Occupation: \_\_\_\_\_ Yrs: \_\_\_\_\_ Employer: \_\_\_\_\_

Computer Used? \_\_\_\_ Hrs per day: \_\_\_\_\_ Dist from computer? \_\_\_\_\_ Do you drive?  Yes  NoDo you have visual difficulty when driving?  Yes  No How many miles to and from work? \_\_\_\_\_Do you have problems with night vision?  Yes  No Do you have problems with glare?  Yes  NoDo you currently wear glasses?  Yes  No Do you wear prescription sunglasses?  Yes  NoDo you wear contacts lenses?  Yes  No Are you interested in contact lenses today?  Yes  NoHow would you rate your current contact lens comfort?  Good  Fair  Poor

What brand of contacts do you wear? \_\_\_\_\_

Do you engage in exercise?  Yes  No Do you take nutritional supplements (vitamins)  Yes  No

Do you smoke? No, Occasional, 1/2 pack, pack/day, 1+ pack/day

Do you drink alcohol? No, Occasional, 1 &gt;1 day

Are you interested in surgical alternatives for vision correction?  Yes  No**Except for Medical Emergency, payment is required at the time of service.** We will be happy to assist you with any insurance you may have. **Please indicate your form of payment today (please check one)**

\_\_\_\_\_ Cash \_\_\_\_\_ Personal Check \_\_\_\_\_ Visa/MasterCard/American Express/Discover

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_**Insurance:****The front office will need copies of current insurance cards in order to process your insurance claim properly.****Name of Primary Carrier:** \_\_\_\_\_ **Name of Insured:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Name of Secondary Carrier:** \_\_\_\_\_ **Name of insured:** \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**By signing below, I authorize any medical or other information about me needed for proper processing of any claim to be released to Medicare or Commercial insurance companies or to their intermediaries. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to me or to the party who accepts assignment. I understand that it is my responsibility to verify benefits and coverage for any services performed and that I will be personally responsible if my insurance does not pay within 90 days after the claim is submitted.****Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Acknowledgement of Notice of Privacy Practices**

As required by the standards of the Health Insurance portability and Accountability act of 1996 (HIPPA)

I have received a copy of the notice of Privacy Practices of Heritage Vision Center on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the notice will be posted in the office of Heritage Vision Center.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this notice of Privacy Practices, I may contact Heritage Vision Center.

**Patient Consent for use and Disclosure of Protected Health Information**

I hereby give my consent for Heritage Vision Center to use and disclose protective health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Heritage Vision Center Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices prior to signing this consent. Heritage Vision Center reserves the right to revise its notice of privacy practices at anytime. A revised Notice of privacy practices may be obtained by forwarding a written request to:

Heritage Vision Center  
Attention: Compliance Officer  
2427 Heritage Village, Ste # 4  
Snellville, GA 30078  
770 978-2020  
Fax: 770 978-1750

With this consent, Heritage Vision Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items and any calls pertaining to my medical clinical care.

With this consent, Heritage Vision Center may mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Heritage Vision Center restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement. By signing this form, I am consenting to Heritage Vision Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Heritage Vision Center may decline to provide treatment to me.

\_\_\_\_\_  
Signature of patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date

# Heritage Vision Center

## Retinal Imaging Patient Consent Form

As part of your eye exam, we at Heritage Vision Center recommend a special diagnostic procedure called retinal imaging. This procedure consists of capturing an image of the back part (retina) of your eye. This is not an X-ray or ultrasound; and nothing will touch your eye. We are simply taking a digital image.

This permanent record is very valuable in assessing the current health of your eye; and for safeguarding the health of specific structures of your eye, such as the retina, optic nerve, macula and blood vessels. It will also serve as an initial point from which to compare, as we follow your health in subsequent years.

**The fee for this additional part of your eye exam is \$25.00.** Depending on your diagnosis, this test may not be covered under your medical insurance or Medicare. Retinal images are also not covered under most vision plans. This office will advise you of your coverage. You may be required to submit a receipt for reimbursement for your insurance provider.

\_\_\_\_\_ Yes, I want to have Retinal Images taken of my eyes for documentation

\_\_\_\_\_ No, I do not want to have Retinal Images taken.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_