Michael Nichols, OD
Robert Bernskoetter, OD
Jeffrey Gamble, OD
Christopher DeRose, OD
Melissa Liepins-Masek, OD

COLUMBIA EYE CONSULTANTS

OPTOMETRY

500 Keene Street, Suite 103
Columbia, MO 65201

1601 Chapel Hill Road, Suite B
Columbia, MO 65203

www.cecoptometry.com
Phone: (573) 874 - 2030
Fax: (573) 449 - 0253

Welcome to Our Practice

Your appointment is on _____ at _____

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Birth Date: _____ / _____ / _____

Email: _____ Social Security #: _____ / _____ / _____

Employer: _____ Occupation: _____

Guardian (If Applicable): _____ Last Eye Exam: _____ / _____ / _____

Medical Doctor: _____

Emergency contact: _____ Phone: _____

How did you hear about our practice: ☐ Recommended by friend or family _____

☐ Your insurance Provider List ☐ Referral from your doctor _____

☐ Internet / Our website ☐ Phone book ☐ Other _____

We are providers for Medicare, Missouri Medicaid, Essence, Cigna, Blue Cross/Blue Shield, Vision Care Direct, UMR, United Healthcare, Coventry, Humana, VSP, EyeMed, Delta Vision, Advantica and Healthlink. If you have other insurance, we will provide you with an itemized receipt on the day of your examination that you may file with your insurance company. If you do not have one of the plans we accept, payment is requested on the day services are rendered.

Insurance Carrier: _____(the staff will need to make a copy of your insurance card)

MEDICAL HISTORY

List the medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List all major surgeries, injuries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: crossed eyes lazy eye glaucoma retinal disease cataracts

eye infections eye injury eye surgery

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old are you current lenses? _____

Do you wear contact lenses? ☐ no ☐ yes

If yes, are they: ☐ soft disposable ☐ Rigid gas permeable ☐ Hybrid ☐ Other

Have you had vision surgery? ☐ no ☐ yes If yes, which? LASIK PRK RK Lens implants OTHER

* Please complete the next page

SOCIAL HISTORY *This information is kept strictly confidential. If you prefer, you may discuss directly with your doctor.*

Do you use tobacco products? ☐ no ☐ yes If yes, type / amount / how long: _____
Do you drink alcohol? ☐ no ☐ yes If yes, type / amount / how long: _____
Do you use illegal drugs? ☐ no ☐ yes If yes, type / amount / how long: _____
Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis ☐ Syphilis ☐ Gonorrhea

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever, Weight Loss/Gain	☐	☐	☐	Allergies / Hay Fever	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
NEUROLOGICAL				Dry Mouth / Throat	☐	☐	☐
Headaches	☐	☐	☐	**RESPIRATORY**			
Migraines	☐	☐	☐	Asthma	☐	☐	☐
Seizures	☐	☐	☐	Emphysema	☐	☐	☐
EYES				**CARDIOVASCULAR**			
Loss of Vision	☐	☐	☐	Diabetes	☐	☐	☐
Blurred Vision	☐	☐	☐	High Blood Pressure	☐	☐	☐
Loss of Peripheral Vision	☐	☐	☐	Vascular Disease	☐	☐	☐
Double Vision	☐	☐	☐	**GASTROINTESTIONAL**			
Mucous Discharge	☐	☐	☐	Diarrhea	☐	☐	☐
Red Eyes	☐	☐	☐	Constipation	☐	☐	☐
Itching	☐	☐	☐	**GENITOURINARY**			
Glare / Halos / Light Sensitivity	☐	☐	☐	Genitals / Kidney / Bladder	☐	☐	☐
Chronic Eye Infections	☐	☐	☐	**BONES / JOINTS / MUSCLES**			
Flashes / Floaters	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Computer Eye Strain	☐	☐	☐	Muscle / Joint Pain	☐	☐	☐
Dry Eyes	☐	☐	☐	**LYMPHATIC**			
ENDOCRINE				Anemia / Bleeding Problems	☐	☐	☐
Thyroid / Other Glands	☐	☐	☐	**ALLERGIC / IMMUNOLOGIC**	☐	☐	☐
				PYSCHIATRIC	☐	☐	☐

If you answered yes to any of the above or have a condition not listed, please explain:

_____

_____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Columbia Eye Consultants Optometry make every effort to inform you of your rights related to your personal health information. Our Notice of Privacy Practices is prominently displayed at our check-in desk. By my signing below, I acknowledge that one of the following statements applies:

- I have read or had explained to me Columbia Eye Consultants Optometry's Notice of Privacy Practices and agree to continue my care with Columbia Eye Consultants Optometry under said terms.

- I was given the opportunity to read Columbia Eye Consultants Optometry's Notice of Privacy Practices and declined but wish to continue my care with Columbia Eye Consultants Optometry under the terms of Columbia Eye Consultants Optometry's privacy policies.

- The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as below:

_____

I have read and understand this form. I am signing it voluntarily.

_____ _____
Patient Signature *Date*

If you are signing as a personal representative of the patient, please indicate your relationship below.

_____ _____
Representative Signature *Relationship to Patient*