Jason P. Gross, M.D.
2460 Willamette Street, Eugene, OR 97405
Phone (541) 683-3744 Fax (541) 683-6672
www.eugeneeyedoctors.com

Welcome to Eugene Eye Clinic!

_____ is scheduled for an appointment on _____

with Dr. Jason Gross. Please arrive at_____to check in.

The office is located on the corner of 24th Place and Willamette Street. Patients may park in our private lot on either side of the building. The office suite is located on the lower level and can be accessed via the stairs or ramp.

- **Please complete all the included forms and bring with you to your appointment to help expedite the registration process.**
- Please remember to bring your insurance cards and photo identification. By providing your correct insurance information, your benefits can be verified and billed correctly. Please refer to the enclosed "Medical vs. Vision Waiver" for explanation of different exam options.
- **Your eyes may or may not be dilated, depending on your specific needs. Most patients are able to drive themselves after dilation, while others may need a driver to accompany them.**
- Please allow up to 2 hours for your initial exam.
- Bring your most recent pair of eyeglasses and a list of your current medications.
- Co-payments and fees for non-covered services are collected at time of check-in. Our office accepts cash, check and Visa/American Express/MasterCard/Discover.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: _____

Name: _____ Preferred Name: _____
(Last) (First) (MI)

Mailing Address: _____ City: _____ St.: _____ Zip: _____

Email Address: _____ Social Security No.: _____

Date of Birth: _____ Preferred Method of Contact: Phone Call / Text / Email

Home phone no.: _____ Cell phone no.: _____ Work phone no.: _____

Sex: M / F Marital Status: S / M / D / W / DP Patient Employer: _____

Emergency Contact Person: _____ Relationship: _____

Home#: _____ Cell#: _____ Work#: _____

Who can we thank for referring you / How did you hear about us? _____

Who is your Primary Care Physician? _____

INSURANCE INFORMATION

If anyone else other than yourself is the subscriber of one or more of your insurance policies, please fill in the information below to assist with timely and accurate billing.

Primary Insurance Co: _____ Subscriber name: _____ Subscriber's DOB: _____

Secondary Insurance Co: _____ Subscriber name: _____ Subscriber's DOB: _____

Legal Guardian or Power of Attorney Information

(This is to be completed when patient is a minor or a Power of Attorney is on file)

Name: _____
Address (if different than patient): _____
Relationship to patient: _____ Date of Birth: _____
Phone #: _____

Signature: _____

MEDICAL HISTORY QUESTIONNAIRE

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

Primary Care Physician: _____ Please list all medication allergies: _____

List any medications you take (including prescriptions & over-the-counter medications): _____

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

REVIEW OF SYSTEMS

Pregnant? Y / N Nursing? Y / N

Do you currently, or have you ever had any of the following:

System	Yes	No
CARDIOVASCULAR		
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Other: _____	❑	❑
RESPIRATORY		
Asthma	❑	❑
Emphysema/COPD	❑	❑
Other: _____	❑	❑
GENITOURINARY		
Prostate / Treatment	❑	❑
List Medication: _____		
ENDOCRINE		
Diabetes	❑	❑
Thyroid Disease	❑	❑
Other: _____	❑	❑
NEUROLOGICAL		
Numbness/Headache/Seizure	❑	❑
Alzheimers/Dementia	❑	❑
Parkinson's	❑	❑
Stroke/ TIA	❑	❑
Other: _____	❑	❑

System	Yes	No
MUSCULAR		
Arthritis	❑	❑
Joint Pain/ Stiffness/Cramps	❑	❑
Back/ Neck Problems	❑	❑
Chronic Pain	❑	❑
Other: _____	❑	❑
GASTROINTESTINAL		
Hep B/ C / Unknown	❑	❑
Gastric Reflux/Ulcers/Diarrhea	❑	❑
Upset Stomach	❑	❑
Other: _____	❑	❑
Skin		
Rash	❑	❑
Pimples	❑	❑
Shingles	❑	❑
MRSA/ MDRO	❑	❑
Cysts/Growths	❑	❑
Other: _____	❑	❑
EARS/ NOSE/ THROAT		
Hard of Hearing	❑	❑
Stuffy Nose / Earache	❑	❑
Other: _____	❑	❑

System	Yes	No
IMMUNOLOGIC / HEMATOLOGY		
Lupus	❑	❑
HIV / Persistent Infections	❑	❑
Prolonged Steroid Use	❑	❑
Other: _____	❑	❑
PSYCHIATRIC / GENERAL		
Night Sweats	❑	❑
Anxiety / Depression	❑	❑
Panic Attack/Claustrophobia	❑	❑
Other: _____	❑	❑
EYES		
Poor/Low Vision	❑	❑
Decreased Vision	❑	❑
Redness	❑	❑
Pain	❑	❑
Other: _____		
FAMILY HISTORY		
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Diabetes	❑	❑
Other Eye Diseases:	❑	❑
CONSTITUTIONAL		
Weight Loss / Gain	❑	❑

SOCIAL HISTORY: Drink Alcohol? Y / N Tobacco? Y/N Rec. Drugs? Y / N

Recent Eye Exam: ____ (Month) / ____ (Year) Previous/Referring Eye Physician: _____

Previous eye surgery? Y / N _____

Refractive eye surgery ? Y / N

Do you wear glasses? Yes ❑ No ❑

If yes, how old is your present pair of glasses? _____

How many pairs of glasses do you currently use? _____

Do you wear contact lenses? Yes ❑ No ❑

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other

How old is your present pair of contacts? _____

Are they comfortable? Yes ❑ No ❑

Mark any you would like to learn more about:

Transitions Sun Lenses	❑
Impact Resistant Lenses	❑
High Index Lenses	❑
Progressive vs. Bifocal Lenses	❑
Intermediate/Computer Lenses	❑
Safety Glasses	❑
Blue Light Blocking Lenses	❑
Polarized vs. Sun Tints	❑
Anti-Reflective/Glare Coating	❑
Indoor Tint	❑
UV Blocking Lenses	❑
Sport Goggles	❑

Glaucoma	❑	Flashes / Floaters	❑
Cataracts	❑	Burning / Itching	❑
Glare Sensitivity	❑	Redness	❑
Dry or Watery Eyes	❑	Eye Pain	❑
Double/ Distorted Vision	❑	Drainage	❑
Loss of Vision	❑	Foreign Body Sensation	❑
Reading Difficulty	❑		

Do you perform fine or close-up work?	❑
Are you outdoors often?	❑
Is safety protection a concern?	❑
Do you have trouble reading signs?	❑
Do you have trouble seeing at night?	❑
Are you bothered by glare and/or lights?	❑
Extended/regular use of computer screens?	❑
Sensitive to bright sunlight?	❑

I have reviewed this history: _____

Jason P. Gross, M.D. / Kent D. Reynolds, O.D. Date

Eugene Eye Clinic, LLC
Jason P. Gross, M.D.
Kent D. Reynolds, O.D.
2460 Willamette Street
Eugene OR, 97405

FINANCIAL AGREEMENT

Welcome to Eugene Eye Clinic, LLC. We would like to inform you about our office's financial and privacy policies.

FOR ALL PATIENTS:

By signing below, I acknowledge that I have provided my current insurance information and I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits directly to Eugene Eye Clinic, LLC for services performed by Drs. Jason Gross & Kent Reynolds. I acknowledge that Eugene Eye Clinic, LLC will bill my insurance as a courtesy. Any services not covered by my insurance will be my responsibility, including services denied due to lack of referral from my primary care provider. Any balances due are to be paid within 90 days of the statement date. After 90 days any balance due will be turned over to an outside collection agency. While payment in full is preferred, you may discuss payment arrangements with the billing staff. I also request payment of government benefits on my behalf to Eugene Eye Clinic, LLC.

Under legislation, patients who do not have insurance (or who are choosing to not bill insurance) have the right to receive a "Good Faith Estimate" explaining how much care will cost. You have the right to dispute the charges if the bill is significantly more than the original estimate. Visit cms.gov/no surprises for more information.

Date: _____ Signature: _____

FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made on my behalf to Eugene Eye Clinic, LLC for services furnished me by Drs. Jason Gross & Kent Reynolds. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eugene Eye Clinic, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Date: _____ Signature: _____

HIPAA Privacy Acknowledgment

We are required by law to protect the privacy of your medical information and to provide you with our written Notice of Privacy Practices. Our Notice of Privacy Practices is available for you to review at your convenience in our waiting areas and front desk. Please take a copy for your records. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices. Your patience and cooperation is greatly appreciated.

Date: _____ Signature: _____

Eugene Eye Clinic, LLC
Jason P. Gross, MD
Kent D. Reynolds, OD
2460 Willamette Street
Eugene, Oregon 97405
541-683-3744

Authorization to Discuss Health Information with **Friends, Family or Caregivers**

Patient name_____Patient DOB_____

_____I authorize Eugene Eye Clinic, LLC to leave a personal voice message or recorded message on the primary phone number I have provided.

Please initial:

_____I do not authorize Eugene Eye Clinic, LLC to discuss my information with anyone other than myself.

OR

I authorize Eugene Eye Clinic, LLC to discuss the areas I have identified below with the individuals listed.

_____ Unlimited access to all information listed below

_____Insurance and Billing information

_____Discuss treatment and diagnosis

Please print:

Name of authorized person	Relationship	Phone Number
Name of authorized person	Relationship	Phone Number
Name of authorized person	Relationship	Phone Number

Patient Signature **Date**

This authorization will remain in effect until revoked or updated by the patient.

Activities of Daily Living Statement

Patient Name: _____

Date of Birth: _____

Indicate the degree of difficulty that you are having in doing each of the following tasks due to your current level of vision. Rate your vision **with correction**, taking into account any glasses that you currently wear. This will help Dr. Gross to assess when you may qualify for and benefit from cataract surgery.

Activity	None	A Little Difficulty	Moderate Difficulty	A Great Deal	Unable to Perform
Reading small print such as medication bottles or food labels	☐	☐	☐	☐	☐
Reading in poor or dim light	☐	☐	☐	☐	☐
Using a cellphone or tablet	☐	☐	☐	☐	☐
Employment activities, computer and office work	☐	☐	☐	☐	☐
Seeing street signs in the distance	☐	☐	☐	☐	☐
Viewing wildlife and scenery outdoors	☐	☐	☐	☐	☐
Watching TV, seeing captions or scores	☐	☐	☐	☐	☐
Seeing at sporting events, plays, movies	☐	☐	☐	☐	☐
Driving a car by day – bright light, sun makes driving difficult	☐	☐	☐	☐	☐
Driving a car by night – glare and halos from oncoming headlights	☐	☐	☐	☐	☐
Recognizing people/faces across the room	☐	☐	☐	☐	☐
Using stairs, steps, or curbs	☐	☐	☐	☐	☐
Doing housework, cooking, cleaning, yardwork	☐	☐	☐	☐	☐
Hobbies or crafts	☐	☐	☐	☐	☐

Other activities _____

Patient Signature: _____ **Date:** _____

EUGENE EYE CLINIC

Vision Preference Questionnaire

Patient Name: _____

In preparation for your cataract surgery, it is important to consider your individual vision and lifestyle preferences. There are a variety of intraocular lenses (IOL) that can be implanted at the time of surgery that may decrease your need for glasses. Your responses to the following questions will help Dr. Gross make a recommendation to you at your cataract evaluation.

Which best describes your desire to wear glasses after surgery?

- ❑ I do not mind wearing **full-time** glasses
- ❑ I do not mind wearing glasses **sometimes**
- ❑ I do not want to wear **any** glasses

After surgery would you be interested in seeing well without glasses in the following situations?

Distance vision (driving, golf/tennis, watching TV and movies, outdoor activities)

- ❑ Prefer no distance glasses
- ❑ I don't mind wearing distance glasses

Intermediate vision (computer, item on a store shelf, music stand)

- ❑ Prefer no intermediate glasses
- ❑ I don't mind wearing intermediate glasses

Near vision (reading books/newspaper, sewing, crossword, craft activities)

- ❑ Prefer no reading glasses
- ❑ I don't mind wearing reading glasses

Do you currently prefer to read without wearing your glasses?

- ❑ Yes
- ❑ No

Which of the following best describes your needs for night vision (such as driving):

- ❑ I need the best vision possible at night, with minimal halos
- ❑ I drive at night, but I would tolerate imperfections or halos
- ❑ Night vision is not particularly important to me

Are you interested in learning more about IOL options to reduce glasses dependence if they have additional out of pocket cost?

- ❑ Yes
- ❑ No

Place an X on the scale to rate your personality:

_____

Easygoing Perfectionist

Patient Signature: _____ Date: _____