# Dr. James D. Hagen

Date:_____/______/_______

Patient's Name:________________________________ Age:_____ Date of Birth:___________

Home Phone:_________________________ Cell Phone:_________________________

Work Phone:______________________ Email:________________________________________

Address:_________________________________ City:__________ State:_____ ZipCode:______

Occupation:____________________________ Employer:_________________________________

OR if student, Name of School:____________________________________ Grade:______

Social Security Number: __________________________

Insurance Carrier:________________________ Policy/ID Number:_________________________

Name of a Parent or Spouse:_________________________________

**I authorize Dr. Hagen to submit any information necessary to my insurance carrier for payment:**

Signature:_____________________________________ Date:__________________

**I do not wish to have my eyes dilated at this time:**

Signature:_____________________________________ Date:__________________

**What is your main reason for seeing Dr. Hagen today?:**______________________________

**What are your current hobbies?:**_______________________________________________

**Are you presently being treated for any medical conditions?** YES or NO

If YES, what are you being treated for?:_____________________________________________

**Are you presently taking any medications?** YES or NO

If YES, please list medications:__________________________________________________

**GENERAL HEALTH** (Past or Present) Check all that apply:

___allergies ___diabetes ___drug sensitivity ___eye disease ___eye or head injury

___glaucoma ___headaches ___heart disease ___high blood pressure ___seizures

___skin conditions ___tuberculosis

**FAMILY HISTORY** Check all that apply:

___cataracts ___diabetes ___eye disease ___glaucoma ___high blood pressure

Name of Family Physician:__________________________ Date of last health exam:__________

**EYE CONDITIONS** Check all that apply:

___distance ___near ___burning ___itching ___tearing ___light sensitivity

___twitching eye lids ___glare at night ___computer eye strain

Who may we thank for referring you to our office?:_____________________________________

**Dr. James D Hagen**

# Optomap Retinal Scan

Dr. Hagen recommends the Optomap Retinal Scan yearly on all patients regardless of age. This scan is painless and only takes a few minutes and is an alternative for eye dilation. The scan enables Dr. Hagen to compare your retina from year to year to see if there are any changes. This test can help to diagnosis: **glaucoma, cataracts, retinal and brain tumors, diabetic retinopathy**, **macular degeneration**, **floaters**, and many more problems.

This procedure is covered by most medical insurances. If you do not have coverage there is only a **$25.00 fee** for the scan.

Please sign below to do this procedure.

Signature:______________________________________ Date:_______________

# No-Show Policy

Dear Patient,

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling 24 hours in advance. If your appointment is NOT cancelled 24 hours in advance there will be a **$25 non-cancellation fee** that cannot be filed to your insurance.

Thank you for understanding

Name of Patient:______________________________

Signature:______________________________ Date:__________________

When patient is under the age of 18 or unable to affix signature:

Name of guardian:_____________________________

Signature of guardian:__________________________ Date:____________

{Dr. James D. Hagen}

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

________________________________
{Please Print Name}

________________________________
{Signature}

________________________________
{Date}

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________