Dear New Patient:

Welcome to our practice! We appreciate your trust and want you to know that we are committed to providing you with the highest quality eye care available today.

Enclosed is our practice information brochure to help acquaint you with our office. Also included are our new patient information forms. We request that you please take a moment to fill out the forms completely and bring them with you to your appointment, as this can expedite your check-in process. Keep in mind that the time spent in our office for a comprehensive new patient exam can be up to 2-3 hours.

On the day of your examination, please bring your health insurance and/or Medicare card, a photo ID, a list of your current medications, and your current eyeglasses. Be prepared to pay any co-payment required by your insurance company. If you are uninsured, please come prepared to pay for your visit.

Should your insurance company require an authorization prior to your appointment, please bring the authorization with you or have it faxed to our office at 775-322-1050. You may need to coordinate this with your primary care physician.

If the examination is for a child, please ensure that a parent or legal guardian is able to accompany them.

For your convenience, we have enclosed a card as a reminder of your scheduled appointment.

We look forward to meeting you soon. Please do not hesitate to contact us if you have any questions prior to your visit at our office.

Drs. Mills, Conklin, Mirbaha,
and the staff of Eye Care Professionals
Legal Name of Patient:
Last: __________________________________________ First: ____________________________ Middle: ____________________________ Nickname: ____________________________

Race: [ ] Caucasian        [ ] American Indian        [ ] Alaska Native        [ ] Asian        [ ] African American        [ ] Native Hawaiian
[ ] Refuse to Answer        [ ] Unknown

Ethnicity: [ ] Hispanic or Latino        [ ] Not Hispanic or Latino        [ ] Refuse to Answer        [ ] Unknown

Sex: [ ] M        [ ] F

Home Address: __________________________________________ City, State, Zip: __________________________________________

Social Security No: ____________________________ E-Mail Address: ____________________________

Mailing Address: __________________________________________

Home Phone: ____________________________ Cell Phone: ____________________________ Work Phone: ____________________________

Employer: ____________________________ Occupation: ____________________________ Date of Birth: ____________________________

Primary Care Physician: ____________________________ Interest In Refractive Surgery: ____________________________

How were you referred to Eye Care Professionals: [ ] Check all that apply [ ] Patient [ ] Optometrist [ ] Internet [ ] TV
[ ] Primary Care Doctor [ ] Insurance Provider [ ] Radio [ ] NV Wolfpack Game [ ] Telephone Directory [ ] Family [ ] Friend

Person Referring You: ____________________________

Preferred Language: ____________________________ Preferred Method Of Contact: [ ] Home Phone    [ ] Cell Phone

MEDICAL and VISION INSURANCE INFORMATION

PRIMARY MEDICAL INS. CO: __________________________________________

Name of Insured: ____________________________ Patient Relationship of Insured: [ ] Self [ ] Spouse [ ] Other

Insured’s Date of Birth: ____________________________ Insured’s Social Security No: ____________________________

Employer: ____________________________ Work Telephone No: ____________________________

SECONDARY MEDICAL INS. CO: __________________________________________

Name of Insured: ____________________________ Patient Relationship of Insured: [ ] Self [ ] Spouse [ ] Other

Insured’s Date of Birth: ____________________________ Insured’s Social Security No: ____________________________

Employer: ____________________________ Work Telephone No: ____________________________

RESPONSIBLE PARTY IF MINOR OR EMERGENCY CONTACT

Name: ____________________________ Social Security No: ____________________________

Address: __________________________________________ Date of Birth: ____________________________

Employer: ____________________________ Occupation: ____________________________

[ ] Work Telephone No: ____________________________

To whom may we release your Medical information:

Name: ____________________________ Relationship: ____________________________ Phone Number: ____________________________

Name: ____________________________ Relationship: ____________________________ Phone Number: ____________________________

NOTICE TO PATIENTS: Payment is required at the time service is rendered unless special arrangements have been made with
our Business Office. This should be done prior to seeing your doctor. I hereby authorize Matthew B. Mills, M.D. and Leyla Mirbaha,
O.D. to furnish information to the insurance carriers, and my doctors concerning my illness and treatment and I hereby assign to
the above doctors all payments for medical services rendered to myself or my dependents. I understand I am responsible for all
services, including any amount not covered by insurance. I have received a copy of Eye Care Professional’s Privacy and
Confidentiality Guidelines.

SIGNATURE: ____________________________ DATE: ____________________________
We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to not disclose to anyone any personal health or identifiable information about our patients without their authorization. We may be required to disclose health and personal information about you in your treatment, to bill for our services and to collect payment from you or your insurance company or to review the quality of service to you. We may disclose information about you for the benefit of governmental benefit programs or in response to a warrant or subpoena. We may be required to provide health information about you to outside business associates such as our transcriptionist. These business associates are required to sign a contract with us stating that any information they come in contact with must be held in the strictest of confidence. We may be required to disclose personal information about you to contact you as a reminder of an appointment, to renew or prescribe medications or for alternative treatment options. We also may need to release medical information about you to your spouse and family members.

Eye Care Professionals will make every effort to protect your health and personal information, however many instances in a medical practice require us to divulge this type of information. If a breach of confidentiality should occur we will notify you immediately. Your personal information will never be disclosed to anyone for marketing purposes.

We have instituted a number of measures to protect you from identity theft. In accordance with the Fair and Accurate Credit Transactions (FACT) Act, we identify, detect and respond to red flags in the handling of patient information. This includes limiting access to patient financial information. In the event that we find any cause for concern, we will notify you immediately.

Eye Care Professionals has my permission to release information concerning my personal health or identifiable information for, but not limited to, the information above.

Printed Name of Patient: ___________________________ Signature: ___________________________
Date: ___________________________ Signature of Parent of Guardian: ___________________________

We reserve the right to make changes to this notice at any time. In the event there is a material change to this notice, the revised notice will be posted.

If you have any complaints concerning our privacy practices you may contact our Privacy Officer, Tracy Waltmon by mail at the above address or email her at: tracy@renoeyecare.com

PATIENT PRIVACY AND CONFIDENTIALITY GUIDELINES ADDENDUM A

A comprehensive exam requires a list of all medications that a patient is currently taking. We will be obtaining a list of your medications electronically. By signing the original Patient and Confidentiality Guidelines form, you are authorizing us to obtain this information.
Dear Eye Care Professionals Patient:

In the course of your care, whether today or in the future, it is important for your doctor to evaluate your retina with a dilated exam. Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements. The majority of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions.

I have read and understand the above information regarding my dilated eye exam.

Patient Name: ________________________________

Patient’s Signature: ________________________________ Date: ________________________________
CANCELLATION OR NO SHOW POLICY FOR DOCTOR APPOINTMENTS

Patient Name: ________________________________________________________________

1. Cancellation/No Show Policy for Doctor Appointment
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

   If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance.

2. Scheduled Appointments
   We understand that delays can happen. However, we must try to keep the other patients and doctors on time.

   If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account Balances
   We will require that patients with self-pay balances do pay their account balances to zero (0) and patients with payment plans must be current prior to receiving further services by our practice.

   Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

   Patients with balances over $100 must make payment arrangements prior to future appointment being made.

Patient/Guardian Signature: ___________________________________________ Date: ____________________________
**VISUAL FUNCTIONING**
Do you have difficulty, even with glasses, with the following activities:  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Driving?</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Reading small print, such as labels on medicine bottles, telephone books, or food labels?</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>Reading a newspaper or book?</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Reading large print book, large numbers on a telephone?</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Seeing steps, stairs, or curbs?</td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>Reading traffic signs, street signs or store signs?</td>
<td>□</td>
</tr>
<tr>
<td>7.</td>
<td>Doing fine handwork like sewing, knitting, crocheting or carpentry?</td>
<td>□</td>
</tr>
<tr>
<td>8.</td>
<td>Writing checks or filling out forms?</td>
<td>□</td>
</tr>
<tr>
<td>9.</td>
<td>Playing games such as bingo, dominos, or card games?</td>
<td>□</td>
</tr>
<tr>
<td>10.</td>
<td>Taking part in sports like bowling, tennis or golf?</td>
<td>□</td>
</tr>
<tr>
<td>11.</td>
<td>Cooking?</td>
<td>□</td>
</tr>
<tr>
<td>12.</td>
<td>Watching television?</td>
<td>□</td>
</tr>
<tr>
<td>13.</td>
<td>Working on the computer?</td>
<td>□</td>
</tr>
</tbody>
</table>

**SYMPTOMS**
Have you been bothered by:  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Poor night vision?</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Seeing ring or halos around lights?</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>Glare caused by headlights or bright sunlight?</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Hazy and/or blurry vision?</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Seeing well in poor or dim light?</td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>Poor color vision?</td>
<td>□</td>
</tr>
<tr>
<td>7.</td>
<td>Double vision?</td>
<td>□</td>
</tr>
<tr>
<td>8.</td>
<td>My vision is worse in one eye than it is in the other eye.</td>
<td>□</td>
</tr>
</tbody>
</table>

Patient’s Signature: __________________________________________  Date: __________________________
HEALTH AND MEDICATION HISTORY

Name: _______________________________ _______________________________ _______________________________

Referring doctor: _______________________________ _______________________________ _______________________________  

What symptoms are you experiencing with your eyes? _______________________________ _______________________________ _______________________________  

Which eye? _______________________________ _______________________________ _______________________________  

How long? _______________________________ _______________________________ _______________________________  

Have you ever been diagnosed with any eye diseases or problems? _______________________________ _______________________________ _______________________________  

Have you ever had eye surgeries/laser treatments or injuries? _______________________________ _______________________________ _______________________________  

Which eye and when? _______________________________ _______________________________ _______________________________  

Name of doctor or clinic that did your eye surgery: _______________________________ _______________________________ _______________________________  

Family history of eye problems? _______________________________ _______________________________ _______________________________  

Preferred pharmacy: _______________________________ _______________________________ _______________________________  

Current prescription medications and dosage/include over the counter medications, vitamins, supplements and eye drops:  

Allergy to medications? _______________________________ _______________________________ _______________________________  

Past or current health problems? _______________________________ _______________________________ _______________________________  

Have you ever had any surgeries and in what year? _______________________________ _______________________________ _______________________________  

Are you a former or current smoker? _______________________________ _______________________________ _______________________________  

Do you drink alcohol? _______________________________ _______________________________ _______________________________  

Do you use recreational drugs? _______________________________ _______________________________ _______________________________  

Current occupation? _______________________________ _______________________________ _______________________________

*Please be as detailed as possible with your answers