Welcome to Our Office

Thank you for choosing us for your eye care needs. Our goal is to provide comprehensive eye care and high-quality eye wear in an environment of superior service, value, and friendliness.

Name _____ **Preferred Name** _____

Pronunciation _____ **DOB** _____ **Phone #** _____

Email _____ **Address** _____

For Office Staff Only:

Routine Vision insurance (ex: EyeMed, Davis/Versant Vision, VSP) is used for general exams to update your eyeglass RX.

Routine Vision Insurance _____ Copay _____ Eligibility _____ Optomap _____

Medical insurance (ex: Independent Health, BC&BS, Univera, Medicare) is used for complete exams or medical visits if there is a medical diagnosis (ex: diabetes, cataracts, glaucoma, macular degeneration, flashes & floaters, allergies, dry eye, pink eye, etc.).

Medical Insurance _____ Copay _____ High Deductible _____

How Did You Hear About Us? (Google, Family/Friends, Insurance, etc.)

How Do You Prefer To Be Billed? ☐ Electronic (via Text) ☐ Paper Mail

Primary Care Physician: Please provide the following information about your primary care doctor

Name of Physician: _____

Name of Office: _____

Pharmacy: Please provide us with your preferred pharmacy

Name of Pharmacy: _____

Location: _____

Do you currently wear? (please circle) Contact Lenses Glasses Neither

If you wear contact lenses, what brand? _____

Please answer the following with your latest prescription:

Do you have visual difficulty when reading?	Yes	No
Do you have visual difficulty working on a computer?	Yes	No
Do you have visual difficulty at distance?	Yes	No
Do you have problems with night vision or glare?	Yes	No

Eye Conditions: Have you been diagnosed with any of the following conditions? Circle all that apply.

Cataract	Dry Eye
Age-related Macular Degeneration	Blepharitis
Glaucoma	Floaters
Diabetes	Flashes of light/Rainbows
Diabetic Retinopathy	Retinal defects or degenerations

Please list any additional conditions:

Eye Concerns: Are you having any of the following eye concerns? Circle all that apply.

Redness	Itching	Discharge
Burning	Tearing	

Please list any additional concerns:

Vision Concerns: Are you having any of the following vision concerns? Circle all that apply.

Blurred vision	Severe sensitivity to lights	Bothersome night glare
Eyestrain	Headache	Double vision
Eye pain	Poor night vision	Total loss of vision

Please list any additional vision concerns:

Review of Systems: Do you have current or past problems with any of the follow? Circle all that apply

General/Constitutional: Chronic fatigue | Loss of Appetite | Cancer | Other: _____

Ears/Nose/Mouth/Throat: Hearing Loss | Sinusitis | Dry Mouth | Laryngitis | Other: _____

Neurological: Multiple Sclerosis | Epilepsy | Cerebral Palsy | Migraines | Other: _____

Psychiatric: Depression | Anxiety | Bipolar | Schizophrenia | Other: _____

Cardiovascular: Hypertension | Stroke | Heart Disease | Vascular Disease | Other: _____

Respiratory: Cigarette Smoke | Asthma | Bronchitis | Emphysema | COPD | Other: _____

Gastrointestinal: Crohn's Disease | Colitis | Ulcer | Other: _____

Genitourinary: Kidney Disease | Prostate Disease/Cancer | STD | Other: _____

Musculoskeletal: Osteoarthritis | Fibromyalgia | Muscular Dystrophy | Ankylosing Spondylitis

Other: _____

Integumentary (Skin): Eczema | Rosacea | Psoriasis | Other: _____

Endocrine: Type 1 Diabetes | Type 2 Diabetes | Hyperthyroid Dysfunction | Hypothyroid Dysfunction

Other: _____

Hematologic/Lymphatic: Elevated cholesterol | Anemia | Large Volume Blood Loss | Leukemia

Other: _____

Allergic/Immunologic: Drug Allergies | Environmental Allergies | Rheumatoid Arthritis | Lupus

Other: _____

Medications and Allergies

Do you take any medications? If so, please list both prescription and non prescription. Yes No

Do you have any allergies? If so, please list. Yes No

Social History - This information is kept strictly confidential.

Use of Alcohol Yes | No : Rare | Moderate | Excessive

Use of Tobacco Yes | No : Previous | Current: Every Day / Some Day

Family Eye and Medical History - **Circle any family members that apply.**

Cancer	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Hypertension	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Hyperthyroid	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Hypothyroid	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Elevated Cholesterol	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Heart Disease	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Cataracts	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Macular Degeneration	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Glaucoma	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Retinal Disease	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Blindness	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____
Crossed Eyes	Mother	Father	Sister	Brother	Son	Daughter	None	Other: _____

Office Policies Consent Form

Consent to Financial Responsibility:

As a courtesy, we will attempt to verify and file your claim with your vision care plan or insurance carrier. However, we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance, allowance overages and any non-covered services as determined by your contract with your carrier. Final liability to the patient is only made after the carrier reviews the claim and determines eligibility and coverage. This process may take up to 1 year. If the insurance provided at the time of the appointment is incorrect, we may not be able to correct the claim to the proper insurance, and you will be responsible for the full payment of the exam and materials.

If your insurance company denies any part of your claim, you will be responsible for the remaining balance. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. We cannot guarantee it is accurate and it is not a guarantee of payment. Please contact your insurance carrier directly if you wish to confirm your individual benefits.

If your vision care plan or health insurance company determines that a particular service is not covered under your plan, your insurer will deny payment for that service. If your insurance company denies payment, you will be personally and fully responsible for payment. If your health insurance company does make payment for services, you will be responsible for any deductible, co-payment/co-insurance, allowance overages and any non-covered services that apply.

Consent to Office Payment Policies:

Insurance co-pays, co-insurance and deductibles must be paid at the time of service. Balances over 120 days old may be subject to interest at an annual rate of 24% (2% per month). A 50% deposit is required for glasses orders. A 100% deposit is required for contact lens orders. Optomap photos are required and cost $29 if not covered by insurance. Contact lens fitting fees range from $60-$120 depending on insurance, experience, and script.

Consent to the Release of Medical Information:

The release of medical information is authorized to any entity that may be liable for your coverage to assist in the reimbursement of benefits that the patient is entitled to, and to other health care providers that may be assisting in your care and treatment.

Consent to Hold Policies:

For the convenience of our patients, we allow billing to be postponed for up to 30 days to allow full usage of insurance benefits. After 2 months, any unused benefits may be lost when the exam is billed.

Consent to No-Show Fees (Advanced Beneficiary Notice):

Any missed appointments or cancellations within 24 hours may be subject to a $50 fine. Exceptions may be made for medical or familial crises. Patients may cancel or reschedule appointments with at least 24 hours' notice at no cost.

I Consent To All of the Above:

Patient Name (Print) _____ Patient or Guardian* Signature _____ Date _____

*If the patient under 18 years of age, or is unable to sign for themselves, his or her guardian must sign for them.