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 _____ **Date of Birth** _____

Pronunciation _____ **Preferred Name**_____

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 _____

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.)

Primary Care Provider: Please provide the following information about your primary care provider

Name of Provider: _____

Name of Office: _____

Pharmacy: Please provide us with your preferred pharmacy

Name of Pharmacy: _____

Location: _____

Current Visual Function: Please tell us about your current corrective lenses

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

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
Do you protect your eyes from sun (UV)?	Yes	No

<u>Eye Conditions:</u> Have you been diagnosed with any of the following conditions? Circle all that apply

Cataract	Dry Eye
Age-related Macular Degeneration	Eye Infection, Inflammation, or Allergy
Glaucoma	Floaters and/or flashes of light
Diabetes	Iritis or Uveitis
Diabetic Retinopathy	Retinal defects or degenerations

Please list any additional conditions:

<u>Eye Concerns:</u> Are you having any of the following eye concerns? Circle all that apply

Redness	Itching	Discharge
Burning	Tearing	

Please list any additional concerns:

<u>Vision Concerns:</u> 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:

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

General/Constitutional: Sudden weight gain or loss | Chronic fever or fatigue | Loss of Appetite | Cancer

Other: _____

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

Neurological: Multiple Sclerosis | Epilepsy | Cerebral Palsy | Tumor | 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: Diabetes | Thyroid dysfunction | Hormonal 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. However if you prefer to discuss directly with the doctor, please leave blank

Use of Alcohol	Yes	No	Rare	Moderate	Excessive
Use of Tobacco	Yes	No	Previous	Current	**Type:** _____

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

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: _____
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: _____

Office Policies Consent Form

Consent to Financial Responsibility:

As a courtesy, we will 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 is only made after the carrier reviews the claim and determines eligibility and coverage.

If your insurance company denies any part of your claim, payment will be expected from you. 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, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible any deductible, co-payment/co-insurance, allowance overages and any non-covered services that applies.

Consent to Office Payment Policies:

Insurance copays, coinsurance 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). For glasses orders to be placed, a 50% deposit is required. For contact lens orders to be placed, a 100% deposit is required. Optomap photos are required and cost $25. Contact lens fitting fees range from $40-$60. Optomap and contact lens fees may or may not be covered by insurance.

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 providing assistance for your care and treatment.

Consent to Hold Policies:

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

I consent to the above:

Patient Name Patient Signature Date

_____ _____ _____