WELCOME

1# Patient Information

Patient _____

Address _____

_____

Sex: ☐ M ☐ F Date of Birth _____

Patient Status: ☐Single ☐Married ☐Other

☐Employed ☐Full-Time Student ☐Part-Time Student

e-mail address _____

Occupation _____

Employer _____

Employer address _____

_____

Primary Care Physician _____

Whom may we thank for referring you? _____

_____

☐Signage ☐Direct Mail ☐Radio

☐Internet ☐Yellow Pages ☐Newspaper

2# Insurance/Responsible Party

Name of Responsible Party _____

Relationship to Patient _____

_____

Primary Insurance Co. _____

Subscriber Name _____

Date of Birth _____

Subscriber ID _____

Secondary Insurance Co. _____

Subscriber Name _____

Date of Birth _____

Subscriber ID _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all changes not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

3# Activities & Social History

Special Occupational Visual Needs _____

_____

Hobbies Sports

_____ _____

_____ _____

_____ _____

Are you interested in contact lenses?

☐ yes ☐ no

Are you interested in Laser Vision Correction?

☐ yes ☐ no

Alcohol Use: ☐Never ☐Rarely ☐Moderate ☐Daily

Tobacco Use: ☐Never ☐Yes ☐Previously

4# Phone Numbers

Work Number _____

Daytime Primary _____

Secondary _____

Mobile/Cell _____

Emergency Contact Name _____

Daytime Phone _____

PATIENT SERVICE AGREEMENT

Thank you for choosing us as your eye health care provider. Prior to receiving care, read and sign the following.

OUR COMMITMENT TO YOU:

- Personalized Eye Health Care
- Patient Education
- Exceptional Service with Infinite Accuracy
- Controlling Costs

- Full payment is due at time of service.
- A Minimum of half down is required at time of order with full payment when glasses and/or contact lenses are picked up.
- We accept cash, checks, credit cards.

INSURANCE

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states, “this is not a guarantee of benefits.”

- As a courtesy, we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that, some perhaps all, of the services provided may be deemed non-covered services by your insurance company.

- If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied.

- The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.

- Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers you are responsible for the balance.

USUAL AND CUSTOMARY RATES

- You are responsible for payment regardless of your insurance company’s arbitrary determination of usual and customary fees.

MINOR PATIENTS

- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized. It is not possible for us to do split billing between accounts.

INTEREST

- We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.

- Collection Proceedings will begin on any outstanding balance in non-compliance with this policy.

Signature of Responsible Party Date

PATIENT HEALTH HISTORY

PLEASE CIRCLE YES OR NO Name: Date:

FAMILY (blood relatives) HEALTH HISTORY

Cataract	No	Yes	Diabetes	No	Yes
Glaucoma	No	Yes	High Blood Pressure	No	Yes
Macular Degeneration	No	Yes	Heart Problems/Stroke	No	Yes
Blindness	No	Yes	Thyroid Problems	No	Yes
Retinal Detachment	No	Yes	Cancer	No	Yes
Other: _____			Arthritis	No	Yes

List any other health problems that run in your family:

_____

_____

_____

SELF - OCULAR HISTORY

Cataract	No	Yes	Injury to Eye or Head	No	Yes
Glaucoma	No	Yes	Ocular Foreign Body Removed	No	Yes
Macular Degeneration	No	Yes	Explain: _____		
Blindness	No	Yes	Amblyopia (lazy eye)	No	Yes
Retinal Detachment	No	Yes	Strabismus (eye turn)	No	Yes
Other:					

Date of Previous eye Exam: _____

Eye Infections	No	Yes
Eye Surgery	No	Yes

Explain: _____

SELF - HEALTH HISTORY / ROS

Name of regular physician: _____

Constitutional Symptoms

Development Disability	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Shortness of Breath	No	Yes

Date: _____
Comment: _____

Ears / Nose / Mouth / Throat

Chronic Sinus Problems	No	Yes
Hearing Loss	No	Yes

Onset Date: _____
Comment: _____

Respiratory

Asthma/Bronchitis	No	Yes
Emphysema	No	Yes

Onset Date: _____
Comment: _____

Hematologic / Lymphatic

Anemia	No	Yes
Leukemia	No	Yes
Large Volume Blood Loss	No	Yes

Onset Date: _____
Comment: _____

Cardiovascular

Heart Problems	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes

Onset Date: _____
Comment: _____

Gastrointestinal

Crohn's Disease	No	Yes
Ulcer	No	Yes

Onset Date: _____
Comment: _____

Genitourinary

Urinary Tract Infections	No	Yes
Kidney Problems	No	Yes
STD's (HIV, Herpes, Chlamydia)	No	Yes

Onset Date: _____
Comment: _____

Endorcine

Non-insulin Dependent Diabetes	No	Yes
Insulin Dependent Diabetes	No	Yes
Thyroid Problems	No	Yes

Onset Date: _____
Comment: _____

Musculoskeletal

Arthritis	No	Yes
Fibromyalgia	No	Yes
Muscular Dystrophy	No	Yes

Onset Date: _____
Comment: _____

Neurological

Multiple Sclerosis	No	Yes
Epilepsy	No	Yes

Onset Date: _____
Comment: _____

Psychiatric

Depression	No	Yes
Nervousness/Panic Disorder	No	Yes
Schizophrenia	No	Yes

Onset Date: _____
Comment: _____

Allergic / Immunologic

HIV/AIDS	No	Yes
Lupus	No	Yes
Cancer	No	Yes
Environmental/Food Allergy	No	Yes

Onset Date: _____
Comment: _____

PATIENT DRUG ALLERGIES OR SENSITIVITIES

_____

MEDICATION TABLE

Medication	Condition	Dosage	Date Begun	ANNUAL UPDATE								

COMMENTS:

For Office Use Only

HEALTH HISTORY & MEDICATIONS REVIEWED

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

Pts. Initials _____ Date _____ ○

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