Welcome to The Eye Doctor

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. **Name** _____ **Nickname** _____ **Date**_____

Street _____ **City** _____ **State**_____ **Zip**_____

Date of Birth____/____/_____ **Age** _____ **Sex M F Social Security** _____-_____-_____ **Email** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Preferred method of communication ☐ Home ☐ Work or ☐ Cell **Reason for today's visit? ☐ Glasses ☐ Contacts ☐ Medical**

If medical, specify: _____

For public health purposes: The government is requesting that health care providers collect the following information from patients:

1. **Blood Pressure**: _____ 2. **Primary Language**: _____
3. **Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other
4. **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Health History

Family Dr. _____ **Family Dr. Phone Number** _____ **Last Physical Exam** _____ **Date of Last Eye Exam** _____

Do you use tobacco products? Y/N **Do you drink alcohol? Y/N** **For Women: Pregnant/Nursing? Y/N** **By Dr.** _____

Do you have any of the following conditions? Please indicate YES or NO

Eyes		**Psychiatric**		**Musculoskeletal**	
Glaucoma	☐Y ☐N	Depression	☐Y ☐N	Arthritis	☐Y ☐N
Cataracts	☐Y ☐N	Anxiety	☐Y ☐N	Osteoarthritis	☐Y ☐N
Macular Degeneration	☐Y ☐N	**Cardiovascular**		Gout	☐Y ☐N
Eye surgery	☐Y ☐N	Hypertension	☐Y ☐N	**Integumentary**	
Retinal Disease	☐Y ☐N	Heart Disease	☐Y ☐N	Shingles	☐Y ☐N
Blindness	☐Y ☐N	Vascular Disease	☐Y ☐N	Breast Cancer	☐Y ☐N
Strabismus/Eye Turn	☐Y ☐N	**Respiratory**		**Endocrine**	
Amblyopia/Lazy Eye	☐Y ☐N	Asthma	☐Y ☐N	Diabetes Type 2	☐Y ☐N
Retinal Disease	☐Y ☐N	Emphysema	☐Y ☐N	Diabetes Type 1	☐Y ☐N
Dry Eye	☐Y ☐N	Sleep Apnea	☐Y ☐N	Thyroid Dysfunction	☐Y ☐N
Constitutional symptoms		Lung Cancer	☐Y ☐N	**Hematologic/Lymphatic**	
Cancer	☐Y ☐N	**Gastrointestinal**		Anemia	☐Y ☐N
Fatigue	☐Y ☐N	Colitis	☐Y ☐N	High Cholesterol	☐Y ☐N
Ear, Nose, Mouth, Throat		Ulcers	☐Y ☐N	Swelling	☐Y ☐N
Hearing Loss	☐Y ☐N	Acid Reflux	☐Y ☐N	**Allergic/Immunologic**	
Sinusitis	☐Y ☐N	Genitourinary	☐Y ☐N	Drug Allergies	☐Y ☐N
Dry Mouth	☐Y ☐N	Kidney Disease	☐Y ☐N	Environmental Allergies	☐Y ☐N
Neurological				Lupus	☐Y ☐N
Multiple Sclerosis	☐Y ☐N	**If you answered YES to diabetes:**		Sjogren's Syndrome	☐Y ☐N
Epilepsy	☐Y ☐N	**Date diagnosed:** _____/_____/_____		Rheumatoid Arthritis	☐Y ☐N
Stroke	☐Y ☐N	**Last Blood Sugar:** _____mg/dl			
Migraines	☐Y ☐N	**Last Hemoglobin A1C:** _____%			

Please list ALL medications:	**What medications are you allergic to:**	**Please list any eye surgeries:**

Please indicate if any family members have or had any of the following conditions and specify relative affected (mother, father, sister, brother, son, daughter)

Glaucoma	_____	Diabetes	_____	Hyperthyroidism	_____
Cataracts	_____	Hypertension	_____	Hypothyroidism	_____
Macular Degeneration	_____	Cancer	_____	Other _____	_____

Lifestyle Questionnaire

Please describe your occupation _____

Computer use: ☐ Y ☐ N **Hobbies & Sports**_____

Insurance Information

Vision Insurance _____
Subscriber's Name _____
Subscriber's DOB ____/____/_____
Patient's Relationship to Insured:
☐ self ☐ child ☐ spouse
Subscriber's ID _____

Medical Insurance (Primary) _____
Subscriber's Name_____
Subscriber's DOB ____/____/_____
Patient's Relationship to Insured:
☐ self ☐ child ☐ spouse
Subscriber's ID _____

Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered. After 45 days, balances are considered delinquent, and are subject to a fee of **$15** for every statement we send you. Checks that fail to clear are subject to a **$50** fee. We MUST be notified at least 24 hours in advance should you need to cancel/reschedule your appointment or you will be charged a fee of **$40**. Failure to show up to your scheduled appointment will also result in a fee of **$40**. You will be personally responsible for this charge because it cannot be billed to your insurance company.
_____ ***(Initial in shaded area)***

Please let us know your **vision** and **medical** insurance **prior** to your visit and if you wish to use it. Although we participate in many insurances, this is not a guarantee of benefits and it is your responsibility to know your insurance benefits and eligibility. Please provide us with your current, valid insurance card(s) as well as any complete referrals or forms required by your insurance. Medical conditions may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. In such cases, it is important that you communicate with our office about your medical insurance and any referrals you may need. If you notify us of your desire to use insurance *after* services are rendered, you may request an itemized receipt to submit to your insurance company for reimbursement directly from your plan. However, be aware that your insurance company may only send you a partial reimbursement or nothing at all, depending on your insurance company's policies, contractual rates and procedures. It is every patient's responsibility to know their insurance plan, referrals and/or certification procedures needed for their insurance plan.
_____ ***(Initial in shaded area)***

Contact lens services incur additional fees that your insurance may not cover. The initial contact lens fitting period includes 2 follow-up visits within 60 days of the initial fitting or otherwise as indicated by your insurance. Should the fitting period elapse before finalizing your contact lens prescription, a new fitting fee applies.
_____ ***((Initial in shaded area)***

The **Health Insurance Portability & Accountability Act of 1996 ("HIPAA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a **"Notice of Privacy Practices Policy"**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Eye Doctor, Notice of Privacy Practices.

Date_____ Patient Name_____ Signature_____

The Doctors or staff may discuss my situation or condition with the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____