

# Welcome to Our Office



Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Pref:  Home  Cell

Email: \_\_\_\_\_ SS# (age 21&over): \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insurance (vision/medical): \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## History

Who is your Primary Care Physician? \_\_\_\_\_

If you are new to our office, when was your last eye exam? \_\_\_\_\_

Do you wear  glasses /  contact lenses?

Contact Brand: \_\_\_\_\_  Daily  2 week  Monthly  Annually

### **Please check all that apply to you:**

- |                        |                          |                     |       |                          |                                 |                          |
|------------------------|--------------------------|---------------------|-------|--------------------------|---------------------------------|--------------------------|
| Eye Injuries/Surgeries | <input type="checkbox"/> | Cancer              | _____ | <input type="checkbox"/> | Intestinal/Stomach Problems     | <input type="checkbox"/> |
| Blindness              | <input type="checkbox"/> | Stroke              |       | <input type="checkbox"/> | Arthritis/Joint Pain            | <input type="checkbox"/> |
| Turned/Lazy Eye        | <input type="checkbox"/> | Heart Disease       |       | <input type="checkbox"/> | Neurological Disorder/Paralysis | <input type="checkbox"/> |
| Cornea Problems        | <input type="checkbox"/> | High Blood Pressure |       | <input type="checkbox"/> | Skin Disorder                   | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | High Cholesterol    |       | <input type="checkbox"/> | HIV/AIDS/Blood Disorder         | <input type="checkbox"/> |
| Smoker                 | <input type="checkbox"/> | Hypo/Hyper Thyroid  |       | <input type="checkbox"/> | Asthma/Chronic Cough            | <input type="checkbox"/> |
| Drink Alcohol          | <input type="checkbox"/> | Anxiety/Depression  |       | <input type="checkbox"/> | Sinus Problems                  | <input type="checkbox"/> |

Cataracts  Self  Parents  Siblings

Glaucoma  Self  Parents  Siblings

Retinal Problems  Self  Parents  Siblings

Macular Degeneration  Self  Parents  Siblings

Diabetic Retinopathy  Self  Parents  Siblings

### **Please list all MEDICATIONS / SUPPLEMENTS: (or we may copy a current list for you)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Fill Out Both Sides > OVER**

**Please list all ALLERGIES/DRUG ALLERGIES:**

---

---

---

**Are you experiencing any of the following eye symptoms?**

- |                        |                          |                          |                          |
|------------------------|--------------------------|--------------------------|--------------------------|
| Blurred/loss of vision | <input type="checkbox"/> | Eye pain                 | <input type="checkbox"/> |
| Floaters/spots         | <input type="checkbox"/> | Burning/Itching          | <input type="checkbox"/> |
| Flashing lights        | <input type="checkbox"/> | Discharge/excess tearing | <input type="checkbox"/> |
| Light sensitivity      | <input type="checkbox"/> | Eye strain               | <input type="checkbox"/> |
| Double vision          | <input type="checkbox"/> | Redness                  | <input type="checkbox"/> |
| Headaches              | <input type="checkbox"/> | Dry/gritty eyes          | <input type="checkbox"/> |
| Poor distance vision   | <input type="checkbox"/> | Stye/Chalazion           | <input type="checkbox"/> |
| Poor near vision       | <input type="checkbox"/> | Other _____              |                          |

**Policy & Authorization:**

Thank you for entrusting the care of your eyes to us. We provide 24 hour access for all eye related problems, including infections, foreign body removals, and glaucoma treatment. Please do not hesitate to ask for assistance if you have any questions or concerns.

Insurance co-pays will collected on the date of service. If you are not able to pay your co-payment today, please reschedule your appointment. For your convenience, our office accepts cash, checks, and debit/credit cards, including CareCredit and American Express.

Our office reserves the right to collect in full for services rendered on the date of service and thereafter, if there's a lapse in coverage and/or termination of the plan. Private pay (no insurance) must pay in full for exam on date of service and make a deposit on any materials ordered. Our returned check fee is \$30.00.

If after 90 days, we have not received payment from your insurance company, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill. It is your responsibility to know the special terms, deductibles, and/or co-pays of your insurance coverage. Your insurance carrier cannot be billed unless you provide necessary documentation. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our office policies and procedures and promote good communication between our patients and our office.

I certify that I have read and understood the above information and have answered all questions accurately to the best of my knowledge. I authorize my eye doctor to release any information including the diagnosis and the records of any examination or treatment rendered to me or my dependent during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to my eye doctor and assume responsibility for all charges that may not be covered.

**Patient (or responsible party) Sign:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_