V·EYE·P
eyecare & eyewear

PERSONAL INFORMATION

O Mr. O Mrs. O Ms. O Dr. — O MALE O FEMALE

Patient's Last Name	Patient's First Name	Middle Initial	Birthdate	SSN

Address	Apt	City	State	Zip

Cell Phone	Work Phone	Employer	Occupation

Vision Insurance Carrier	Name of Policy Holder	Policy Holder Birthdate	Policy Holder SSN
Medical Insurance Carrier	Name of Policy Holder	Policy Holder Birthdate	Policy Holder SSN

Subscriber ID #	Group #.

Emergency Contact Name	Relationship	Emergency Contact Phone

Email Address (Please allow us to send you appointment reminders, glasses & contact lens order notifications, and special offers.)	**How did you hear about us?**

MEDICAL & VISUAL HISTORY

Reason for Today's Visit: O Glasses O Contact Lenses O Lasik Surgery O Eye Irritation/Pain Other: ________

Last Eye Exam: ________
Name of Doctor: ________

Please check if you wear:
O Glasses Age of current pair______
O Contact Lenses Age of current pair______

List any medical conditions you are being treated for and for how long: (Including Pregnancy)

List any and all medications you are currently taking (include hormones/birth control/non-prescription/herbal remedies)

Are you ***allergic*** to any medications? O No. No Known Drug Allergies O Yes: If so please list.

Check all medical conditions that *you* currently have, or have ever had, in the following areas:

O Allergies/Hay Fever
O Anemia/Bleeding
O Arthritis/Muscle Pain
O Asthma
O Cancer Type:________
O Cataracts
O Chronic Bronchitis
O Chronic Cough
O Diabetes
O Dry Throat/Mouth
O Gastro/Intestinal
O Headaches/Migraines
O Head Trauma
O High Blood Pressure
O Past Trauma________
O Psychiatric Disorders
O Seizures
O Sinus Congestion
O Skin Rash
O Thyroid Disease
O Weight Loss/Gain
O Other: ________

Check all eye conditions that *you* currently have, or have ever had, in the following areas:

O Color Deficiency
O Corneal Transplant
O Eye Surgery Type: ________
O Glaucoma Type: ________
O Infection of Eye or Lid
O Keratoconus
O Lazy Eye/Strabismus
O Macular Degeneration
O Past Eye Injuries: ________
O Prosthesis
O Ptosis (drooping lid)
O Retinitis Pigmentosa
O Blurred Vision Distance
O Blurred Vision Near
O Distorted Vision (halos)
O Double Vision
O Dry Eyes/Redness
O Epiphora (excess tearing)
O Eye Pain or Soreness
O Floaters or Spots
O Fluctuating Vision
O Foreign Body Sensation
O Glare/Light Sensitivity
O Headaches
O Itchy/Burning Eyes
O Light Flashes
O Loss of Vision
O Mucous Discharge
O Night Vision Problems
O Sandy or Gritty Feeling
O Tired Eyes
O Vision Therapy
O Other: ________

Check conditions that are present in *other* family members:

O Cancer Type:________
O Cataracts before age 60
O Diabetes
O Glaucoma
O Heart Disease
O High Blood Pressure
O High Cholesterol
O Macular Degeneration
O Stroke/TIA's
O Other EYE Diseases (please list) ________
O Other Inherited Conditions (please list) ________

CONTACT LENS HISTORY

Have you ever worn contacts? O Yes O No
Are you here for a contact lens prescription today? O Yes O No
When was the last time you wore contacts?________
How many days a month do you sleep in your contacts? ________

Please check which kind of contacts you currently wear, or are interested in:

O Daily Wear (1 pair for the year) O Extended Wear (can sleep in) O Disposable: How often do you throw each pair away?________
O Rigid Gas Permeable O Bifocal/Monovision O Toric/Astigmatism O Colors

Problems with contacts: O Dry O Uncomfortable O Blurry O Other ________

O Brand of Current Contacts:________
Solution you currently use: ________

SOCIAL HISTORY, HOBBIES & INTERESTS

O Indoor/Outdoor Sports
O Musical Instruments
O Exercising
O Tobacco Products
O Travel /Vacation
O Alcohol
O Swim
O Recreational Drug Use
O Computers _____hrs/day
O Reading
O Other: ________

NOTICE OF PRIVACY PRACTICES

HIPPA – Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for V•EYE•P to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). V•EYE•P's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. V•EYE•P reserves the right to revise its Notice of Privacy Practices at anytime. With this consent, V•EYE•P can call me at home or other alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, obtaining insurance information, billing and any calls pertaining to my clinical care. With this consent, V•EYE•P may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, statements and/ or insurance information. By signing this form, I am consenting to V•EYE•P the use and disclose of my PHI to carry out TPO. My signature below signifies my understanding and willingness to comply with the above policies.

______________________________ ______________

Signature of patient (or guardian) Date

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

When provided the necessary insurance information prior to an appointment, the staff of V•EYE•P makes every attempt to verify patient's benefits. In addition, the staff will gladly file insurance claims on behalf of the patient. The insurance carrier will review the claim and accept or deny coverage as they deem appropriate. Should the insurance company deny coverage, it is the patient's responsibility to pay any and all of the balance to V•EYE•P. To be better prepared, patients should attempt to know their coverage including deductibles, co-pays and non covered services.

The staff of V•EYE•P can give you a general idea of what may or may not be covered by your insurance plan before seeing the doctor. However, we can not always know for certain what services will be provided by the doctor before the examination.

Whether a visit will be filed with a vision carrier or a medical carrier is dependent on several factors including but not limited to patient's reason for visit, type of exam performed, and diagnoses. Any diagnosis other than a routine vision diagnosis will result in a medical claim submittal. At times, patients may be able to use both medical and vision benefits to maximize patients' benefits.

By signing below, I acknowledge that I have read and understand the above.

______________________________ ______________

Signature of patient (or guardian) Date

SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand I am responsible for my bill.
- I authorize my doctor to act as my agent in helping obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I authorize a copy of this authorization to be used in place of the original

______________________________ ______________

Signature of patient (or guardian) Date

Our office offers digital scanning technology (OPTOS) that allows us to view the inside of your eyes without the use of dilation drops. This new technology allows us to evaluate your retina for problems such as **macular degeneration, retinal holes, retinal detachments, glaucoma, hypertension, and diabetic retinopathy.** This technology also helps in explaining why **headaches or changes in vision** may be occurring.

EARLY DETECTION IS CRUCIAL!

We strongly recommend that **ALL** patients have a thorough examination of their retina every year. **WITHOUT THE RETINAL EXAMINATION, THE DOCTOR CANNOT FULLY ASSESS THE HEALTH OF YOUR EYES.** There is an additional fee for this new technology, unless our patient care coordinator has explained otherwise.

______ **I elect to have an OPTOMAP digital scan of my retinas today ($39.00)**

- The optomap digital imaging system captures more than 80% of your retina in one panoramic image, whereas traditional methods reveal only 10-12% of the retina at one time.
- The optomap enhances your eye doctor's ability to detect the earliest sign of disease that presents on your retina.
- The optomap takes only seconds to perform, is not painful, does not blur your vision, and typically does not require dilation.
- It provides a digital photo that is shown to you and kept for your records.

______ **I elect to have a dilated exam of my eyes today and I understand that the dilation may cause blurry vision, light sensitivity, and headaches for up to 8 hrs, and may impair my ability to drive.**

____
Patient Name

________________________ ________________________
Patient or Guardian Signature Date