Patient Information

Date: _____

PATIENT PERSONAL INFORMATION			**Please Print Clearly**
Last Name:		**First Name:**	**MI:**
Date of Birth:	**Age:**	**Sex (M/F):**	**SSN #**
Mailing Address:			**Home Phone: ( )**
City:	**State:**	**Zip:**	**Cell Phone: ( )**
Employer/School Name:			**Work Phone: ( )**
Employer Address:			**Work Related Visit (Y/N):**
Occupation:			**Marital Status:** ☐ **S** ☐ **M** ☐ **W** ☐ **D**
Spouse's Name:			
Primary Physician:			
Referred by:			
Race:	**Ethnicity:**		**Language:**

INSURANCE INFORMATION		
Primary Insurance Co.	**Insurance #**	**Group #**
Insured:		
Insured Date of Birth:		**Sex (M/F):**
Relationship of Patient to Insured:		
Secondary Insured Co.	**Insurance #**	**Group #**
Insured:		
Insured Date of Birth:		**Sex (M/F):**
Relationship of Patient to Insured:		

RESPONSIBLE PARTY	(Fill out only if other than the patient)		
Last Name:	**First Name:**	**MI:**	**Sex (M/F)**
Street Address:	**City:**	**State:**	**Zip:**
Date of Birth:	**Phone ( )**	**SSN #**	
Relationship:		**Employer:**	

EMERGENCY CONTACT	
Name of person not living with you:	**Relationship:**
Phone number (home): ( )	**Phone number (work): ( )**

PAYMENT POLICY:

All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at the time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurance carriers

AUTHORIZATION OF PAYMENT:

I hereby authorize the provider to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

Signed: _____ **Date:**_____

Please answer the following questions about your medical status and history

1. Have your ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   Yes ☐ No ☐ If YES please explain:

2. Have you ever had any eye disease (glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If Yes please explain:
3. Have you ever had surgery?
   Yes ☐ No ☐ If YES, please provide date and reason:

4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide date and reason:

5. Do you take any medication?
   Yes ☐ No ☐ If YES, please list:

   Do you take any EYE medications?
   Yes ☐ No ☐ If YES, please list:

6. Do you have any food or drug allergies?
   Yes ☐ No ☐ If YES, please list:

Review of Systems:

Do you currently have any of the following problems

	YES	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue ?	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)?	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, coughing)?	☐	☐	
Gastrointestinal problems(e.g. heartburn, abdominal pain, diarrhea, vomiting)?	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)?	☐	☐	
Skin problems(e.g. Rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)?	☐	☐	
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)?	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye disease run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
Yes ☐ No ☐ If YES, please provide date and reason:

Do you smoke? Yes ☐ No ☐ If YES, how much?_____
Do you drink alcohol? Yes ☐ No ☐ If YES, how much?_____
Drug use? Yes ☐ No ☐ If YES, please explain?_____
If employed, how many hours per week do you work?_____

WELCOME TO EYE ASSOCIATES

INSURANCE POLICY

In order to serve you properly and keep cost down we feel it is necessary to define our financial policies. We are happy to file the forms necessary to see that you receive the full benefits of your coverage: however, we cannot guarantee any estimated coverage. Because the insurance policy is an arrangement between you and the insurance, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" fees. Additionally, we are not responsible if your insurance company representative tells us something is covered at X%, and then later denies payment or pays less that stated. Our involvement will be limited to supplying factual information to facilitate claim processing. If for some reason your insurance company has not paid their portion within 30 days from the start of treatment you are responsible for the payment at that time. All charges are your responsibility whether your insurance company pays or does not pay. If you should have any questions regarding your charges for each appointment, pleases feel free to ask us.

REFERRALS

If you have an insurance which requires a referral it is your responsibility to obtain the referral from your primary care physician **before your appointment.** Otherwise, the visit will not be covered by insurance and you will be responsible for the payment. Please notify is if your insurance requires pre-authorization for office procedures.

REFRACTION POLICY

During your visit a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is not only a necessary and essential portion of your eye exam, but in many cases is the sole reason for the appointment. Please be aware that this is a non-covered service by Medicare and most other insurance companies and is the responsibility of the patient. Our office currently charges $50.00 for this procedure. We appreciate your cooperation in collecting this fee at the time of service.

I have read the above and fully understand my financial responsibility.

Signature:_____Date:_____

ROUTINE EYE EXAMINATION POLICY

It is also important that you understand that most medical insurance plans, including Medicare, do not cover routine eye examinations. A routine eye examination is when no medical eye problem is known or suspected, or if you are just coming in for a glasses check. In this case, you would be responsible for the charges for that visit. Some **vision plans** will cover routine examinations. However, since we are a medical eye doctor, we are **NOT** on most vision plans. Please let us know if you have a question regarding routine eye exam coverage.

I have read the above and fully understand my financial responsibility.

Signature_____Date_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OR PRIVACY PRACTICES

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of patient or Representative	**Date**	**Description of Representative**