V·EYE·P

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. **PERSONAL INFORMATION** ◯ MALE ◯ 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 (Providing this allows us to send appt reminders, order notifications and promotional offers & events)

How did you hear about us?

MEDICAL & VISUAL HISTORY

Reason for Today's Visit: ◯ Glasses ◯ Contact Lenses ◯ LASIK Surgery ◯ Eye Irritation/Pain ◯ Other:_____

Last Eye Exam _____

Name of Doctor: _____

Please check if you wear:
◯ Glasses Age of current pair:
◯ 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? ◯ No. No known drug allergies. ◯ Yes. If so, please list.

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

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

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

◯ Color Deficiency
◯ Corneal Transplant
◯ Eye Surgery (Type):_____
◯ Glaucoma (Type):_____
◯ Infection of Eye or Lid
◯ Keratoconus
◯ Lazy Eye/Strabismus
◯ Macular Degeneration
◯ Past Eye Injuries:_____
◯ Prosthesis
◯ Ptosis (drooping lid)
◯ Retinitis Pigmentosa
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision (halos)
◯ Double Vision
◯ Dry Eyes/Redness
◯ Epiphora (excess tearing)
◯ Eye Pain or Soreness
◯ Floaters or Spots
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision (halos)
◯ Double Vision
◯ Dry Eyes/Redness
◯ Epiphora (excess tearing)
◯ Eye Pain or Soreness
◯ Floaters or Spots
◯ Night Vision Problems
◯ Sandy/Gritty Feeling
◯ Tired Eyes
◯ Vision Therapy
◯ Other:_____

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

◯ Cancer Type:_____
◯ Cataracts before age 60
◯ Other *eye* diseases (please list)_____
◯ Other Inherited Conditions (please list)_____
◯ Diabetes
◯ Glaucoma
◯ Heart Disease
◯ High Blood Pressure
◯ High Cholesterol
◯ Macular Degeneration
◯ Stroke/TIA's

CONTACT LENS HISTORY

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

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

◯ Daily Wear (1 pair for the year)
◯ Extended Wear (can sleep in)
◯ Disposable: How often do you throw each pair away?_____
◯ Rigid Gas Permeable
◯ Bifocal/Monovision
◯ Toric/Astigmatism
◯ Colors
Problems with contacts: *(please circle)* dry, uncomfortable, blurry, other
◯ Blurry
◯ Other_____
Brand of current contacts:_____
Solution you currently use:_____

SOCIAL HISTORY, HOBBIES & INTERESTS

◯ Indoor/Outdoor Sports
◯ Exercising
◯ Travel/Vacation
◯ Swim
◯ Computers___hrs/day
◯ Musical Instruments
◯ Tobacco Products
◯ Alcohol
◯ Recreational Drug Use
◯ Reading
◯ Other:_____

V·EYE·P

NOTICE OF PRIVACY PRACTICES

HIPAA - 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 locations and leave a message or 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 locations 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 willingingess 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 cannot 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 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 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 THAT 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.**
- **I AUTHORIZE EMAILS & TEXT MESSAGES BE SENT TO ME FOR APPT REMINDERS, ORDER NOTIFICATIONS AND PROMOTIONAL OFFERS & EVENTS.**

Signature of patient (or guardian) ***Date***

V·EYE·P
eyecare & eyewear

OPTOMAP DIGITAL EXAM

Our office offers digital scanning technology that allows us to view the inside of your eyes without the use of medications. Our 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.**

_____ **I elect to have an OPTOMAP digital scan of my retinas today ($35.00).**

- **In depth view of nearly the entire retina**.
  The optomap captures more than 80% of your retina in one panoramic image, whereas traditional methods reveal only 10% of the retina at one time.
- **Precision and early detection.**
  The optomap enhances your eye doctor's ability to detect the earliest sign of disease that presents on your retina.
- **Fast, easy and comfortable!**
  The optomap takes only seconds to perform, is not painful, and typically does not require dilation.

_____ **I elect to have the PUPIL DILATION retinal exam.**

- **Additional 30 minutes exam time.** Eye medications will be used to dilate the eyes.
- **Side effects include:**
  - burning on instillation
  - blurry vision at near and long distances lasting up to 8 hours
  - light sensitivity (please wear sunglasses after dilation)
  - headaches/nausea
- **Avoid driving and operating machinery** until the effects wear off.

_____ _____

PATIENT SIGNATURE (PARENT/ LEGAL GUARDIAN) DATE OF SERVICE

_____
V EYE P Staff

_____
Pt Acct #