



EYES ON SUNSET

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☐ Male ☐ Female ☐ Other:

Legal Name: _____ Preferred Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ SSN: _____

Email: _____ Occupation: _____

☐ Home/☐ Cell #: _____ Guardian: _____

Please provide your vision and medical insurance cards

VISION INSURANCE VS MEDICAL INSURANCE

Vision insurance is used when you are seen for a *routine wellness eye exam* that includes a refractive exam to update glasses or contact lens prescriptions.

Medical insurance is used when you are seen for a *medical eye condition*. Some examples include **diabetes, glaucoma, cataracts, floaters, retinal detachment, or symptoms of dry, itchy, burning or red eyes.**

Based on your exam, we will bill the insurance that is appropriate for your visit. **Copay, coinsurance and deductibles** may apply.

I have read and understand the difference between vision and medical insurance. Any medical eye conditions that (initial) are evaluated or treated will be billed to medical insurance.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (**HIPPA**) is a federal law designated to protect the privacy of your health information. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process insurance claims, and mail/email/text exam recalls.

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and the final determination can only be made when the claim is processed. It is my responsibility to provide my insurance information for billing purposes. I understand that billing any secondary insurance is my responsibility. A bank service fee of **\$40** will be charged on any check returned for insufficient funds. Accounts 90 days or older will be submitted to a collection agency with a **30%** fee of the balance amount. I am aware exam fees are **NON-REFUNDABLE** after services have been provided. **If an appointment is not cancelled within 24 hours in advance, a service fee of \$25 will be charged and will not be covered by insurance.**

GLASSES RECHECK POLICY

We will recheck any prescription at no cost **within 60 days** of the original date of service. Rechecks will not be performed after 60 days and a new exam will be required, additional fees apply.

CONTACT LENS EVALUATION FEE

The Fairness to Contact Lens Consumers Act requires all contact lens wearers to have a contact lens examination to evaluate the health of the eyes and the fit of the contacts on the cornea. This service is *in addition* to your refractive exam and is typically not covered by vision insurance. The evaluation fee covers all follow-up visits for **60 days**. **THIS FEE IS DUE AT THE DATE OF YOUR SERVICE AND IS NON-REFUNDABLE.**

YES, I would like a Contact Lens Prescription and accept the responsibility of the Contact Lens Evaluation Fee.

NO, I decline the Contact Lens Evaluation acknowledging that I will NOT be given a Contact Lens Prescription

I have read and acknowledge the Privacy Notice, Financial Agreement, Glasses Recheck, and Contact Lens Evaluation Fee. I consent to digital delivery of my prescription. By signing below, I agree to these terms and my responsibilities as a patient.

Patient, Parent or Guardian Signature

Date

→→ PLEASE COMPLETE THE BACK PAGE →→

MEDICAL HISTORY

Past Surgeries: _____

Medication: _____

Allergies to Medication: ☐NO ☐YES If yes, explain: _____

Pregnant or Nursing: ☐NO ☐YES If yes, how far along? _____

FAMILY HISTORY

☐ Adopted

Please note any family history with the following conditions:

	No	Mom	Dad	Sibling	Grandparent
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye turn / Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

This information is required by insurance carrier and is kept strictly confidential.

Smoking history:
☐ Never ☐ Former ☐ Some days ☐ Every day

Alcohol use:
☐ None ☐ Occasional ☐ 1 drink/day ☐ 2+drinks/day

Illegal drugs:
☐ No ☐ Yes

REVIEW OF SYSTEM

Do you currently have any problems with the following:

CONSTITUTIONAL		EAR / NOSE / THROAT		ENDOCRINE	
Fever	No Yes	Allergies	No Yes	Diabetes	No Yes
Weight Gain/Loss	No Yes	Chronic Cough	No Yes	Thyroid	No Yes
		Sinus Congestion	No Yes		
NEUROLOGICAL		RESPIRATORY		PSYCHIATRIC	
Headache	No Yes	Asthma	No Yes	Anxiety	No Yes
Migraine	No Yes	Bronchitis	No Yes	Bipolar	No Yes
Multiple Sclerosis	No Yes			Depression	No Yes
Seizure	No Yes				
		VASCULAR / CARDIOVASCULAR		GENITOURINARY	
EYES		Heart Disease	No Yes	Genital/Kidney/Bladder	No Yes
Medical	Blurry vision w/ glasses	High Blood Pressure	No Yes		
	Sudden loss of vision	High Cholesterol	No Yes	GASTROINTESINAL	
	Double Vision	Stroke	No Yes	Crohn's Disease	No Yes
	Flashes of light/Floaters			IBS	No Yes
	Red Eye	BONES / JOINTS / MUSCLES		LYMPHATIC/HEMATOLOGIC	
	Eye Pain	Arthritis	No Yes	Anemia	No Yes
	Sandy/Gritty feeling	Joint Pain	No Yes		
Itchy Eye	Muscle Pain	No Yes			
	Dry Eye/Watery Eye	No Yes			

If you answered YES to any of the above or have a condition not listed, please explain:
