

# 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: <input type="radio"/> Glasses <input type="radio"/> Contact Lenses	Last Eye Exam _____	Please check if you wear:	
<input type="radio"/> LASIK Surgery <input type="radio"/> Eye Irritation/Pain <input type="radio"/> Other: _____	Name of Doctor: _____	<input type="radio"/> Glasses	<input type="radio"/> Contact Lenses
		Age of current pair: _____	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:

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

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

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

Check conditions that are present in other family members:

- |  |                                |   |  |
|--|--------------------------------|---|--|
| <input type="radio"/> Cancer Type: _____                             | <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease       | <input type="radio"/> Macular Degeneration |
| <input type="radio"/> Cataracts before age 60                        | <input type="radio"/> Glaucoma | <input type="radio"/> High Blood Pressure | <input type="radio"/> Stroke/TIA's         |
| <input type="radio"/> Other eye diseases (please list) _____         |                                | <input type="radio"/> High Cholesterol    |  |
| <input type="radio"/> Other Inherited Conditions (please list) _____ |                                |   |  |

## CONTACT LENS HISTORY

Have you ever worn contacts? <input type="radio"/> Yes <input type="radio"/> No	Are you here for a contact lens prescription today? <input type="radio"/> Yes <input type="radio"/> 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:			
<input type="radio"/> Daily Wear (1 pair for the year)	<input type="radio"/> Extended Wear (can sleep in)	<input type="radio"/> Disposable: How often do you throw each pair away? _____	
<input type="radio"/> Rigid Gas Permeable	<input type="radio"/> Bifocal/Monovision	<input type="radio"/> Toric/Astigmatism	<input type="radio"/> Colors
Problems with contacts: (please circle) dry, uncomfortable, blurry, other		<input type="radio"/> Blurry	<input type="radio"/> Other: _____
Brand of current contacts: _____	Solution you currently use: _____		

## SOCIAL HISTORY, HOBBIES & INTERESTS

- |   |  |                                       |   |  |                                    |
|---|--|---------------------------------------|---|--|------------------------------------|
| <input type="radio"/> Indoor/Outdoor Sports | <input type="radio"/> Exercising       | <input type="radio"/> Travel/Vacation | <input type="radio"/> Swim                  | <input type="radio"/> Computers ___hrs/day |                                    |
| <input type="radio"/> Musical Instruments   | <input type="radio"/> Tobacco Products | <input type="radio"/> Alcohol         | <input type="radio"/> Recreational Drug Use | <input type="radio"/> Reading              | <input type="radio"/> Other: _____ |

# V·EYE·P

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## NOTICE OF PRIVACY PRACTICES

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### 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 willingness to comply with the above policies.

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*Signature of patient (or guardian)*

*Date*

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## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

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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.

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*Signature of patient (or guardian)*

*Date*

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## SIGNATURE ON FILE

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- 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.

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*Signature of patient (or guardian)*

*Date*

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## 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 (\$39.00)**.

- **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 #