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Date ___/___/_____

Demographics

First Name _____ Middle Name _____ Last Name _____

Suffix _____ Date of Birth _____ Last 4 of SSN _____

Address _____

City _____ State _____ Zip Code _____

Sex ○ Male ○ Female Marital Status ○ Single ○ Married ○ Other

What is your Preferred phone number? ☐ Cell ☐ Home ☐ Work

Cell phone _____ Home phone _____ Work phone _____

Email _____

Race _____

Ethnicity _____

Employment Status

○ Employed Full Time	○ Employed Part Time	○ Student Full Time	○ Unknown
○ Student Part Time	○ Not Employed	○ Retired	○ None
○ Homemaker	○ Active Military	○ Disabled	

What is your driver's license number? _____

Who is your employer _____

What is your position/occupation? _____

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Insurance Information

Primary Insurance

Insurance Company Name _____

Policy Holder _____

Relationship of Policy Holder _____

Policy Holder Date of Birth _____

Policy Number _____

Secondary Insurance

Insurance Company Name _____

Policy Holder _____

Relationship of Policy Holder _____

Policy Holder Date of Birth _____

Policy Number _____

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Reason for Visit

Please tell us why you're coming to see us _____

_____

If another provider sent you to us, who?_____

Eye History

When was your last eye exam?_____

Who was your previous eye doctor?_____

Have you ever had any eye injuries, surgeries for your eyes, or been diagnosed with an eye disease?

- ☐ No conditions
- ☐ Glaucoma suspect
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age related macular degeneration
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory disorders
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal degeneration
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry eye
- ☐ Nystagmus
- ☐ Retinal/degeneration/ hole/detachment
- ☐ Other

Do you wear glasses? ○ Yes ○ No

How old are your glasses?_____

What don't you like about your current glasses?_____

_____

Do you wear contact lenses? ○ Yes ○ No

What brand of contact lenses do you wear?_____

What is your contact lens prescription for the right eye_____

What is your contact lens prescription for the left eye_____

What solution(s) do you use to clean your contact lenses?_____

Do you sleep in your contact lenses? ○ Yes ○ No

How often do you start a new pair of lenses? ○ Daily ○ Monthly ○ Quarterly ○ Other

What don't you like about your contact lenses?_____

_____

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History of Patient Illness

Are you having any problems with your eyes? ○ Yes ○ No

What problem are you having? _____

Which eye is affected? _____

How would you describe the quality of the problem?

☐ Awareness ☐ Bothersome ☐ Painful

How would you describe the severity of the problem?

○ Mild ○ Moderate ○ Severe

When did the problem begin? _____

Have you ever had this problem before?

○ New Condition ○ Return of Previous Condition ○ Ongoing Condition

Is the problem associated with any of the following conditions?

○ Associated with injury ○ Associated with infection
○ Associated with medical condition ○ Associated with surgery

What have you done to try to make the problem better?

☐ Taking medication ☐ Taking drops ☐ Treated by another provider

Are any symptoms associated with the problem?

☐ Burning ☐ Loss of vision ☐ Pain
☐ Tearing ☐ Headache ☐ None
☐ Mattering ☐ Photophobia
☐ Flashes ☐ Diplopia
☐ Floaters ☐ Red
☐ Loss of sharpness ☐ Itching

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Review of Systems

Allergy/Immunology
- [ ] Drug Allergies
- [ ] Environmental Allergies
- [ ] Rheumatoid Allergies
- [ ] Lupus
- [ ] Sjogren's Syndrome
- [ ] Other
- [ ] Negative

Hematology/Lymphatic
- [ ] Anemia
- [ ] Large Volume Blood Loss
- [ ] Ulcer
- [ ] Hypercholesteremia
- [ ] Other
- [ ] Negative

Cardiovascular
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Vascular Disease
- [ ] Congestive Heart Failure
- [ ] Stroke/CVA
- [ ] Other
- [ ] Negative

Psychological
- [ ] Depression
- [ ] Attention Deficit
- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Other
- [ ] Negative

Gastrointestinal
- [ ] Crohns
- [ ] Colitis
- [ ] Ulcer
- [ ] Acid Reflux
- [ ] Celiac Disease
- [ ] Other
- [ ] Negative

Neurological
- [ ] Multiple Sclerosis
- [ ] Cerebral Palsy
- [ ] Tumors
- [ ] Stroke/CVA
- [ ] Migraines
- [ ] Autism Spectrum Disorder
- [ ] Epilepsy
- [ ] Other
- [ ] Negative

Ear, Nose & Throat
- [ ] Hearing Loss
- [ ] Sinusitis
- [ ] Dry Mouth
- [ ] Laryngitis
- [ ] Other
- [ ] Negative

Integumentary (SKIN)
- [ ] Eczema
- [ ] Rosacea
- [ ] Psoriasis
- [ ] Herpes Simplex/ Cold Sores
- [ ] Herpes Zoster/ Shingles
- [ ] Other
- [ ] Negative

Genitourinary
- [ ] Kidney Disease
- [ ] Prostate Disease
- [ ] STD-herpetic/chlamydia
- [ ] Benign Prostate Hypertrophy
- [ ] Pregnant
- [ ] Nursing
- [ ] Herpes
- [ ] Chlamydia
- [ ] Other
- [ ] Negative

Musculoskeletal
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Muscular Dystrophy
- [ ] Ankylosing Spondylitis
- [ ] Osteoporosis
- [ ] Gout
- [ ] Osteoarthritis
- [ ] Other
- [ ] Negative

Constitution
(e.g. fever, weight loss, etc)
- [ ] Developmental Disabilities
- [ ] Cancer
- [ ] Fatigue Syndrome
- [ ] Other
- [ ] Negative

Respiratory
- [ ] CigaretteSmoker
- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Chronic Obstruction
- [ ] Sleep Apnea
- [ ] Other
- [ ] Negative

Endocrine
- [ ] Type 2 Diabetes Mellitus
- [ ] Type 1 Diabetes Mellitus
- [ ] Thyroid dysfunction
- [ ] Hormonal Dysfunction
- [ ] Other
- [ ] Negative

Comments:

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Medications

Do you take any prescription or non-prescription medications? ○ Yes ○ No

What is the name of your medications?

Please feel free to share any information about your medications here

What pharmacy do you use? _____

Allergies

Are you allergic to any medications? ○ Yes ○ No

What medication(s) are you allergic to?

What allergic(s) are you allergic to?

Do you have any other allergies? ○ Yes ○ No

What other allergies do you have?

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Past, Family and Social History

Who is your primary care physician? _____

Diabetes History

Do you have diabetes? ○ Yes ○ No

How long have you had diabetes? _____

What physician is treating your diabetes? _____

How frequently do you see your physician for diabetes care? _____

What was your last hemoglobin A1c reading? _____

Family Medical History

Does anyone in your family have any of the following medical conditions?

☐ None ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Other

Does anyone in your family have any of the following eye conditions?

☐ None ☐ Severe Myopia ☐ Macular Degeneration ☐ Cataract ☐ Nystagmus
☐ Glaucoma suspect ☐ Severe Hyperopia ☐ Amblyopia ☐ Dry eye
☐ Glaucoma ☐ Strabismus ☐ Retinal Detachment ☐ Other

Social History

Do you drink alcohol? ○ Yes ○ No ○ Unknown

How often do you drink alcohol? _____

Do you use tobacco products? ○ Yes ○ No ○ Unknown

What tobacco products do you use?

☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless tobacco ☐ Other ☐ No preference

How often do you use tobacco products? _____

Do you currently or have you ever smoked tobacco products?

☐ Smoker Current status unknown ☐ Never smoker ☐ Former smoker
☐ Current every day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker
☐ Current some day smoker ☐ Unknown if ever smoked

Do you have any hobbies? _____

Retinal Imaging

Consent for Retinal Imaging in Place of Dilation

At our office, we offer **digital retinal imaging** as an alternative to **dilating eye drops** for evaluating the health of the back of the eye (the retina, optic nerve, and blood vessels).

Please review the following information before choosing this option.

What Is Retinal Imaging?

Retinal imaging is a **high-resolution photograph** of the inside of your eyes. It allows the doctor to:

- Detect and monitor conditions such as glaucoma, macular degeneration, diabetic retinopathy, and more
- Store and compare images over time for better disease management
- Perform a detailed retinal exam **without the side effects** of dilation

Benefits of Retinal Imaging

- No blurred vision or light sensitivity
- No waiting for dilation to take effect
- Immediate results available for review
- Enhanced ability to **track changes over time**

Limitations

- Not always a complete substitute for dilation
- May not provide sufficient detail in certain cases (e.g., high prescriptions, small pupils, or suspicious findings)
- Your doctor may still recommend dilation **based on your symptoms or findings**

Retinal imaging may not be covered by your insurance plan and can require a separate fee. Our staff will inform you of the cost prior to the procedure.

Signing below, you agree to the following:

- I have been offered retinal imaging as an alternative to dilation.

- I understand the purpose, benefits, and limitations of this procedure.
- I agree to pay any associated fees not covered by my insurance.
- I understand that my doctor may still recommend dilation if needed for a comprehensive evaluation.

Signature: _____ Date: _____

HIPPA

Employees and partners of the practice will have access to confidential information, both written and oral, in the course of their employment and job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently an employee of the practice and/or any information. Any other disclosures may only occur at the direction may only occur at the direction of the Privacy Office or by patient authorization.

I have read and understand the practice's policies with regards to privacy and Security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my employment including, but not limited to, financial, technical, or propriety information of the organization and personal and sensitive information regarding patients, employees, and vendors. I understand that inappropriate disclosure or release of patient information is grounds for termination.

Signature: _____ Date: _____

Financial Agreement

Insurance Billing Policy

At our office, we are committed to helping you maximize your insurance benefits and understand your financial responsibilities. Please review the following information regarding how we handle insurance billing:

1. Insurance as a Courtesy

We will bill your **insurance company as a courtesy** to you. To do this, we must have **accurate and complete insurance information** at the time of your visit. If this information is not available or valid, you will be responsible for payment in full.

2. Patient Responsibility

While we make every effort to verify your benefits, it is ultimately **your responsibility** to:

- Know your vision and/or medical insurance coverage
- Be aware of any **deductibles, co-pays, co-insurance, or exclusions**
- Provide **referrals** if required by your plan

You are financially responsible for any charges **not covered** by your insurance, including:

- Refractions (vision test for glasses), if not covered
- Contact lens evaluations
- Out-of-network services
- Any non-covered procedures or materials
- Any non-covered procedures or materials

3. Vision vs. Medical Insurance

- **Vision insurance** (e.g., VSP, EyeMed) typically covers routine eye exams, glasses, and contact lenses only.
- **Medical insurance** (e.g., Aetna, Blue Cross, Medicare) is used if you have an eye condition that requires medical evaluation (e.g., eye infections, glaucoma, dry eyes, diabetic exams, lid inflammation).

If your visit involves both routine and medical concerns, we may need to bill your **medical insurance** for the exam and your **vision insurance** for materials.

4. Co-Pays and Deductibles

Any **co-pays or deductibles** are due at the time of service, even if we are billing your insurance. These fees are required by your insurer and cannot be waived.

5. Non-Covered Services

Some services we provide may **not be covered** by your plan. In these cases, we will inform you in advance and provide a cost estimate. Payment is due at the time of service.

6. Assignment of Benefits

By signing our financial policy, you authorize our office to **submit claims** on your behalf and receive payment directly from your insurance carrier.

7. Returned Payments / Balances

Any returned checks are subject to a fee. If your insurance denies a claim or pays less than expected, you are responsible for the remaining balance.

Signature: _____ Date: _____

Contact Lens Policy

1. What Is a Prescription Check?

A prescription check (also called a glasses recheck or remake check) is a **follow-up visit** to evaluate your vision with the **new prescription** if you are experiencing difficulties such as:

- Blurred vision
- Headaches
- Eyestrain
- Distorted or uncomfortable vision

It is not a full exam, but a **limited check** to verify or adjust your glasses prescription if needed. We offer **one complimentary prescription recheck** within **30 days of the original exam date** for glasses ordered using the provided prescription.

After this period, a **refraction fee of $60** may apply, as your vision may have changed or a more comprehensive exam may be required.

Contact Lens Fitting and Evaluation Policy

We are committed to providing you with safe, comfortable, and effective contact lens wear. A contact lens evaluation is a **separate service** from your comprehensive eye exam and is **not always covered** by insurance. Please read the following information carefully.

1. What is a Contact Lens Fitting or Evaluation?

A contact lens evaluation includes:

- Precise **measurements** of the cornea and tear film
- Assessment of **prescription needs** specific to contacts (which may differ from glasses)
- Evaluation of **fit, movement, and eye health** while wearing contacts
- Trial lens fitting, if applicable
- **Instruction and training** for new wearers on insertion, removal, and care
- Follow-up visits to ensure the lenses are safe and effective

This process ensures that your lenses are medically appropriate, fit properly, and provide optimal vision.

2. Additional Fee

A contact lens evaluation is a **separate fee** from your routine eye exam. This fee varies based on:

- Whether you're a **new or existing contact lens wearer**
- The type of lenses prescribed (e.g., toric, multifocal, RGP)
- Complexity of the fitting and follow-up care required

Insurance coverage for this service varies. If not covered, the patient is responsible for the fee. Our staff will inform you of the cost before proceeding.

3. Types of Contact Lenses We Fit

We fit a variety of contact lenses, including:

- Soft disposable (daily, biweekly, monthly)
- Toric lenses for astigmatism
- Multifocal lenses
- Monovision correction
- Rigid gas permeable (RGP)

4. Prescription Expiration and Release

By law, contact lens prescriptions are valid for **one year** unless medically necessary for a shorter duration. A current contact lens evaluation is **required annually** to renew or release your contact lens prescription. We can not release your contact lens prescription once it has expired.

5. Follow-Up Visits

Follow-up visits may be required to:

- Finalize the prescription
- Monitor eye health
- Make adjustments in fit or power

These visits are **included** in the contact lens evaluation fee for up to 90 **days**. Visits beyond this period may incur additional fees.

6. Online Purchases and Prescription Release

You are entitled to receive a **copy of your contact lens prescription** upon completion of your fitting, along with your glasses prescription. Signing this acknowledges we have provided both.

7. Trial Lenses

Trial lenses are provided **only** as part of an active contact lens fitting. We do not dispense trials to patients after the script has been finalized and released.

Signature: _____ Date: _____

Cancellation Policy

We understand that unforeseen circumstances can arise. If you need to cancel or reschedule your appointment, please contact our office as soon as possible to avoid the cancellation fee. Thank you for your understanding and cooperation.

- **Cancellation Notice**: We require a minimum of 24 hours notice to cancel or reschedule an appointment
- **In-Office Cancellations**: If you choose to cancel your appointment while present in the office, a $45 fee will be applied.
- **Late Cancellations and No-Shows**: If you cancel your appointment with less than 24 hours notice or fail to attend your scheduled appointment, a $45 fee will be applied
- **Fee Application**: The cancellation fee will be billed directly to you and is not covered by insurance.

Signature: _____ Date: _____