FashionEye CENTER

Welcome to Our Office

Patient Information

Today's Date _____ /_____ /_____

Last Name _____ First _____ MI _____

Street _____

City _____ State _____ Zip Code _____

Date of Birth (Patient)_____ /_____ /_____ Age _____

Sex M / F

Home Phone ( )_____-_____ Work Phone ( )_____-_____

Cell Phone ( )_____-_____ Emergency Contact ( )_____-_____

E-mail Address _____

Communication Preference Text E-mail Phone

If under 18, Guarantor _____

Guarantor SSN _____

Employer (or School) _____

Occupation (or Grade) _____

What is the major purpose of this visit? _____

_____

Vision Insurance _____

Subscriber Name _____

Subscriber ID _____ Subscriber Birth Date _____ /_____ /_____

Medical Insurance _____ Medical Insurance ID# _____

Group _____

Primary Care Physician _____ Phone / FAX _____

Insurance Policy

Fashion Eye Center accepts most insurance plans. In the event we should fail to collect any co-payments from your insurance company, we will bill you the correct amount allowed within your plan.

Vision plans do not cover medical eye care (the diagnosis, management or treatement of current or potential eye health problems).

- It may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called "coordination of benefits" to do this properly and to minimize your out-of-pocket expense.
- Your insurance policy is a contract between you and your insurance company. We will attempt to verify your coverage ahead of your appointment. Although we are familiar with most plans, we may not know exactly what your coverage is for a particular product or service. It is your responsibility to understand your plan before your appointment.
- Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card on file in case we should need to submit a claim on your behalf.

I understand my financial obligations and agree to pay all charges that are not paid by my insurance plan:

Guarantor on Account _____

Date _____ /_____ /_____

Medical History

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Unusual weight losses/gains	❑	❑
Diabetes/Endocrine	❑	❑
Thyroid	❑	❑
Digestive	❑	❑
Genitourinary	❑	❑
Kidney	❑	❑
Ears/Nose/Throat	❑	❑
Blood/Lymph	❑	❑
Immunologic	❑	❑
Skin/ Eczema/Rashes	❑	❑
Arthritis	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Cancer	❑	❑

Have you recently experienced, been diagnosed or treated for any of the following?

- ❑ Blurry vision
- ❑ Burning
- ❑ Occasional dryness
- ❑ Tearing
- ❑ Double vision
- ❑ Flashes of light
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Headaches
- ❑ Itchiness
- ❑ Sunlight sensitivity
- ❑ Trouble seeing/driving at night
- ❑ Uncomfortable glasses
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Corneal abrasions
- ❑ Eye infections
- ❑ Eye injury
- ❑ Glaucoma
- ❑ Macular degeneration
- ❑ Retinal detachment
- ❑ Iritis/Uveitis
- ❑ Lazy eye
- ❑ Other eye disorders

Date of Last Eye Exam _____ /_____ /_____

By Whom? _____

Do you wear glasses? (circle) Distance, Near, Bifocal, Progressive

Have you ever tried contact lenses? ❑ Yes ❑ No

Are you interested in trying contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer contacts that do not require daily cleaning? ❑ Yes ❑ No

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Patient History

Family Physician _____

Location _____

Date of Last Physical Check-up _____

Current Medications (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills and what they treat)

_____ _____

_____ _____

_____ _____

_____ _____

Are you nursing/pregnant? ❑ Yes ❑ No

Any allergies to medications? ❑ Yes ❑ No

If so, what medications? _____

_____

Have you had any eye surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco,alcohol, or other substances? ❑ Yes ❑ No

Has a blood relative ever been diagnosed with the following?
If yes, what is their relationship to you?

- Blindness ❑_____
- Cataracts at young age ❑_____
- Corneal problems ❑_____
- Diabetes ❑_____
- Glaucoma ❑_____
- Heart disease ❑_____
- Lazy eye ❑_____
- Macular degeneration ❑_____
- Retinal issues ❑_____

Do you..... (check box if your answer is yes)

- ❑ work at a computer?
- ❑ have prescription sun wear?
- ❑ enjoy fishing, boating or skiing?
- ❑ prefer not to wear your glasses at times?
- ❑ have more than 1 pair of current Rx eyewear?
- ❑...have children or other family members needing eye care?

If you wear bifocals, does the visible line bother you? ❑ Yes ❑ No

Signature On File

I authorize release of any information to my insurance company necessary to process a claim; I authorize payment to be made directly to Fashion Eye Center; I authorize use of this form on all my insurance submissions and permit a copy of this authorization to be used in place of the original; I understand that I am responsible for payment of any charges not paid for by my insurance, including any co-payments not collected at time of order; I understand this office does not in any way guarantee payment for services/eyewear by accepting my insurance plan and that all insurance benefit amounts quoted are estimates received from your insurance company and actual amount due from you may change after insurance claim processing. I have also read, or been offered a copy of our HIPPA Privacy Practices.

X _____

Date _____ /_____ /_____