



# Welcome to Our Office

## Patient Information

DATE (Today) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Last Name \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth (Patient) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Sex M | F

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ OK to text? Y / N

E-mail Address \_\_\_\_\_

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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Advanced Testing Offered .....

In our continued efforts to bring the most advanced technology to our patients, we are proud to announce the inclusion of the Optos Daytona Retinal Exam as an integral part of your exam today.

Our doctors are invested in the early diagnosis of conditions such as: macular degeneration, glaucoma, retina holes or detachments, and systemic diseases such as diabetes, stroke and high blood pressure. These conditions can lead to serious ocular or health problems, including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.

### Optos Retinal Exam Benefits:

- An in-depth view of the retinal layers where diseases can start.
- Provides an Optos digital image at the time of your exam to discuss and answer questions about your eye health.
- This also provides an annual, permanent record on your medical file, which gives doctors comparisons for tracking and diagnosing potential eye disease.

### Optos Retinal Exam

No blurry vision  
 No light sensitivity  
 Takes less than two minutes  
 Permanent digital image

### Dilation

Blurry vision 3-5 hours  
 Light sensitive 4-6 hours  
 25 minutes longer exam time  
 No permanent record of retina

Insurance typically does not cover any advanced screening technology beyond the general exam, but it is eligible for flexible spending account reimbursement. Our doctors highly recommend the Optos Retinal Exam for all patients. This will be done as an enhancement to the general eye exam for a fee of \$25.

Our recommendation is an annual retinal evaluation including Optos Retinal photo; if there are any risk factors detected we will proceed with a dilation to further assess any concerns.

- Accept Optos Photo                       I would prefer to be dilated

## 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 treatment 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	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Skin/ Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

## 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              | <input type="checkbox"/> |
| Cataracts at young age | <input type="checkbox"/> |
| Corneal problems       | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> |
| Glaucoma               | <input type="checkbox"/> |
| Heart disease          | <input type="checkbox"/> |
| Lazy eye               | <input type="checkbox"/> |
| Macular degeneration   | <input type="checkbox"/> |
| Retinal issues         | <input type="checkbox"/> |

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

Orthokeratology is a non-surgical, affordable way to treat nearsightedness and astigmatism. It rids the need for daytime glasses.  
 Would you like to learn more?  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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_