

Please note any conditions (Self, Parents, Grandparents, Siblings, and Children; living or deceased):

<u>HEALTH CONDITION/DISEASE</u>	<u>YES</u>	<u>NO</u>	<u>UNSURE</u>	<u>RELATIONSHIP TO YOU</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (Integumentary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular/Cardiovascular				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary				
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal				
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constitutional				
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological				
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine				
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Mouth/Throat				
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones/Joints/Muscles				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>EYE DISEASE/CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>UNSURE</u>	<u>RELATIONSHIP TO YOU</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery/Infection/Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
“Lazy Eye”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

VISION CORRECTION HISTORY

Do you wear glasses? Yes No If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? Yes No If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other _____

Are they comfortable? Yes No

Contact lens replacement schedule: _____

Type of contact lens solution used: _____

Are you planning to get new glasses today? Yes No Only if Prescription Changes

Are you planning to get new contact lenses today? Yes No Only if Prescription Changes

I would like to learn about: Computer Glasses Sports Glasses Polarized Sunglasses

Are you interested in finding out more about Laser Vision Correction? Yes No

EYE HISTORY - Are you currently having any of the following symptoms?

	<u>YES</u>	<u>NO</u>	<u>UNSURE</u>		<u>YES</u>	<u>NO</u>	<u>UNSURE</u>
Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy / Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tearing/Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scratchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a symptom not listed, please explain and list any medication used:

Doctor's Signature

Date Reviewed

OFFICE FINANCIAL RESPONSIBILITY

- Payment in full is due at the time of service unless an arrangement has been made prior to your scheduled appointment. ***We accept cash, check, Visa, MasterCard, American Express and Discover.***
- All checks returned by the bank for insufficient funds will incur a \$30.00 bank fee. After we notify you, you have seven days to remit payment in full, plus the additional \$30.00. Failure to do so will result in your account being turned over to a collection agency.
- I understand that should my account balance become 30 days past due my account will begin to accrue interest calculated at 1.5% monthly (18% per annum). I also understand that if the office is required to place my account with a collection agency or attorney for collection, I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest from the initial statement date (1.5% monthly, 18% per annum) and all incurred costs in collecting the amount owed.
- We require full payment for materials (glasses and contact lenses) at the time the order is placed.
- I understand that if I require a **referral** for my major medical insurance I am responsible for arriving with the referral from my Primary Care Physician (PCP) or I will be responsible for paying, in-full, for all services rendered at the time of the examination.
- I understand that all patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This contact lens medical evaluation is performed every 12- months whether or not new contact lenses are purchased. I understand there is an additional charge for this service. Most medical insurance companies consider contact lenses "cosmetic" and not "medically necessary;" therefore, **services related to contact lenses are not covered and will be my responsibility.** Certain vision discount plans (VSP, Davis Vision, etc) do have benefits for contact lenses and discounts toward the contact lens medical evaluation. If you do not wish to incur any contact lens charges, please inform our staff **before** your examination and remove your contact lenses before your examination begins. However, if this is your choice we will not be able to dispense any contact lenses to you, write a prescription for contact lenses, or be responsible for any contact lenses you might continue to wear.
- I acknowledge that during the course of the examination, the Doctor may request further specialized tests due to medical history, family history or to better diagnose any potential eye health problems. In many cases these tests are covered by your major medical plan. If your plan should not cover the recommended testing these charges will be your responsibility and due at the time of your appointment.
- As your eye care provider it is our responsibility to provide you and your family with the best possible health care. Please remember, your insurance policy is an agreement arrived at between you and your insurance company and not between your insurance company and your provider. Each insurance company has dozens of plans; all different. It is impossible for our staff to have complete knowledge of each one.

For our insurance patients:

- *If you plan to use your insurance as a form of payment* you must present a current insurance ID card to our staff no later than at the time of your appointment; if your **vision plan** is not listed on your major medical insurance card you must inform us of the vision plan's name so we can research and determine your coverage. If you have not presented your insurance information prior to the completion of your examination ***we will not be able to provide refunds, order cancellations or adjustment to fees AFTER your order has been placed and initial services have been rendered,*** however, we will help you submit your claim for reimbursement.
 - Although we pre-authorize services and materials prior to your arrival, we are told by your insurance company that they will not guarantee payment of the claim until they have processed your individual claim. If your insurance company declines the claim submitted, you will be responsible for the balance owed.
 - If your deductible has not been met, your visit will not be covered by your insurance company and you **will** be charged today. We will file the claim with your insurance company so that the amount you paid today is credited toward your deductible amount.
 - Co-payments are due at the time of your visit.
- If there are any questions concerning your bill, either today or when received by mail, it is your responsibility to ask. If we do not hear from you we will assume that you understand, and agree to pay the charges listed.
 - ***Your signature indicates that you have read, understand and agree to all of the above policies.***

Signature: _____

(Person Responsible for the Account)

Date: _____