



Date / / Name Gender M F Birth Date / / Address City State Zip Home Phone Cell Phone Work Phone Email Occupation Soc.Sec.# How did you first hear of our office?

Responsible Party Information (If Self, leave blank)

Name Birth Date / / Address City State Zip Home Phone Cell Phone Employer Work Phone Soc. Sec.# Relationship to Patient

Insurance Information

Vision Insurance Company Primary Medical Insurance Company Secondary Medical Insurance Company Member's Soc. Sec. # Member's Name ID# Member's Birth Date / / Employer Group#

Medical Information

What is your primary reason for this exam? Age of present glasses Last eye exam from Dr.

Do you or any blood relatives have: (Please circle No or Self or Family and indicate family member)

- Diabetes No Self Family: Hypertension No Self Family: Heart Disease No Self Family: Respiratory Problems No Self Family: Gastrointestinal Issues No Self Family: Thyroid Problems No Self Family: Muscle pain or Arthritis No Self Family: Allergies/Hay Fever No Self Family: Migraines No Self Family: Anemia/Bleeding Issues No Self Family: Glaucoma No Self Family: Macular Degeneration No Self Family: Cataracts No Self Family: Retinal Detachment No Self Family:

Do you use tobacco products? No Yes Are you taking any medications? No Yes (If so, please list)

Are you allergic to any medications? No Yes (If so, please list)

Have you ever had an eye injury, infection, or surgery? (If so, please detail)

Do you ever experience double vision? No Yes Do you have frequent headaches? No Yes Are you interested in LASIK surgery? No Yes

Contact Lens History

Do you currently wear contact lenses? No Yes
Do you sleep in your contact lenses? No Yes
What type of contacts do you wear? Rigid Gas Permeable (Hard) Soft Astigmatism (Toric) Bifocal
If disposable, how often do you replace your lenses? _____
What solutions do you use to care for your lenses? _____
Are you having any problems with your lenses? No Yes, please detail _____

Office Policies

Payment is expected at the time services are rendered (including insurance co-payments).

Patient/guarantor is responsible for balances after insurance processing.

A \$15.00 fee will be added to patient balance for each returned check.

Cancellations for ordered product after 24 hours are subject to a 10% restocking fee.

Prescriptions are valid for *one year from the exam date*.

We can exchange *unopened* boxes of contact lenses (spherical lenses only) that were purchased from our office. There are no refunds for *opened* boxes or boxes that have been *written on*.

There are NO exchanges or refunds for *colored* contact lenses.

Insurance

For patients with insurance that we accept directly, we submit all claims to your vision/primary insurance company and accept assignment of insurance benefits. Patients with managed care must pay their co-pay at the time services are rendered as stated in your benefits plan. If your insurance company has not paid the full balance within 60 days, then the balance of your account will be your responsibility. Please be advised that some (and perhaps all) of the services we render may be considered "non-covered" by your insurance company. Your insurance plan is a contract between you and your insurance company. *You are personally responsible for payment of any non-covered services.*

Please call if your insurance changes so we can update our records for you.

Please read thoroughly to indicate you have read office policies and sign below:

1. I understand that all responsibility for payment for vision care services for myself or my dependents is due and payable at the time services are rendered, unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% monthly finance charge (18%APR) may be added to my account, in addition to any collection charges.
2. I understand that where appropriate, credit bureau reports may be filed.
3. I understand that it is my responsibility to advise your office of any changes to the personal or insurance information on this form.
4. I authorize the use of my social security number to file my vision/medical claims.
5. I authorize that my signature on this form may be used as a "Signature on File" for filing insurance claims.
6. I acknowledge that HIPAA forms are posted and are available upon request and online.
7. I have read and understand the policies outlined on this form.

Patient Signature (Parent for Minors) _____ Date _____