

WELCOME TO OUR OFFICE

Name _____
 SS# _____
 Street _____
 City _____ State _____ Zip _____
 Home Ph _____ Work Ph _____
 E-Mail _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Date of Birth _____ Age _____ Sex: M ___ F ___

Today's Date _____ Date of Last Exam _____

Any problems with your present contact lenses or glasses? _____

Spouse (or Parent's name) _____

Spouse (or Parent's Work Phone) _____

Vision Insurance _____

Health Insurance _____

New Patients Only: How did you hear about our office? _____

How will you settle your account today?

Check Cash Credit Card

Review of Systems Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
EYES				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE				Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Family History

Please note any family history (grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
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"/>	_____
Glaucoma	<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"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Medications (Rx or Over the Counter)

	No	Yes	Name of Medication
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diuretics (Water Pills)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure Pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleeping Tablets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Drops	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Meds? (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol/Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently under the care of a physician?	No	Yes	_____
Name of physician	_____		
Allergies to meds?	_____		

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print) _____

Medicare Number _____

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Eyecare Associates of Dewitt, for services furnished by me by Eyecare Associates of Dewitt. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any informatoin needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eyecare Associates of Dewitt accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eyecare Associates of Dewitt, if possible or otherwise to me.

3. **Release of Information:** Eyecare Associates of Dewitt may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eyecare Associates of Dewitt for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eyecare Associates of Dewitt may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statue, or regulation. A copy of this authorization may be used in place of the original

4. **Other Insurance:** I understand that Eyecare Associates of Dewitt maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Eyecare Associates of Dewitt has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges on all services rendered to me by Eyecare Associates of Dewitt if I belong to a plan that does not appear on the above mentioned list.

5. **Non-Covered Services:** I understand that Eyecare Associates of Dewitt's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eyecare Associates of Dewitt to obtain necessary health care service plan authorizations.

6. **Financial Agreement:** I agree that in return for the services provided to the patient by Eyecare Associates of Dewitt, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eyecare Associates of Dewitt for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eyecare Associates of Dewitt. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eyecare Associates of Dewitt. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date