# V·EYE·P

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. **PERSONAL INFORMATION** ◯ MALE ◯ FEMALE

| Patient's Last Name | Patient's First Name | Middle Initial | Birthdate | SSN |
|---|---|---|---|---|
| | | | | |

| Address | APT | City | State | Zip |
|---|---|---|---|---|
| | | | | |

| Cell Phone | Work Phone | Employer | Occupation |
|---|---|---|---|
| | | | |

| Vision Insurance Carrier | Name of Policy Holder | Policy Holder Birthdate | Policy Holder SSN |
|---|---|---|---|
| | | | |

| Medical Insurance Carrier | Name of Policy Holder | Policy Holder Birthdate | Policy Holder SSN |
|---|---|---|---|
| | | | |

| Subscriber ID# | Group # |
|---|---|
| | |

| Emergency Contact Name | Relationship | Emergency Contact Phone |
|---|---|---|
| | | |

**Email Address** (Providing this allows us to send appt reminders, order notifications and promotional offers & events)

**How did you hear about us?**

## MEDICAL & VISUAL HISTORY

**Reason for Today's Visit:** ◯ Glasses ◯ Contact Lenses ◯ LASIK Surgery ◯ Eye Irritation/Pain ◯ Other:_____

**Last Eye Exam** _____

**Name of Doctor:** _____

**Please check if you wear:**
◯ Glasses Age of current pair:
◯ Contact Lenses Age of current pair:

**List any medical conditions you are being treated for and for how long (including pregnancy):**

**List any and all medications you are currently taking (include hormones/birth control/non-prescription/herbal remedies)**

**Are you *allergic* to any medications?** ◯ No. No known drug allergies. ◯ Yes. If so, please list.

**Check all medical conditions that you currently have, or have ever had, in the following areas:**

◯ Allergies/Hay Fever
◯ Anemia/Bleeding
◯ Arthritis/Muscle Pain
◯ Asthma
◯ Cancer Type:_____
◯ Cataracts
◯ Chronic Bronchitis
◯ Chronic Cough
◯ Diabetes
◯ Dry Throat/Mouth
◯ Gastro/Intestinal
◯ Headaches/Migraines
◯ Head Trauma
◯ High Blood Pressure
◯ Past Trauma:_____
◯ Psychiatric Disorders
◯ Seizures
◯ Sinus Congestion
◯ Skin Rash
◯ Thyroid Disease
◯ Weight Loss/Gain
◯ Other:_____

**Check all eye conditions that you currently have, or have ever had in the following areas:**

◯ Color Deficiency
◯ Corneal Transplant
◯ Eye Surgery (Type):_____
◯ Glaucoma (Type):_____
◯ Infection of Eye or Lid
◯ Keratoconus
◯ Lazy Eye/Strabismus
◯ Macular Degeneration
◯ Past Eye Injuries:_____
◯ Prosthesis
◯ Ptosis (drooping lid)
◯ Retinitis Pigmentosa
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision (halos)
◯ Double Vision
◯ Dry Eyes/Redness
◯ Epiphora (excess tearing)
◯ Eye Pain or Soreness
◯ Floaters or Spots
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision (halos)
◯ Double Vision
◯ Dry Eyes/Redness
◯ Epiphora (excess tearing)
◯ Eye Pain or Soreness
◯ Floaters or Spots
◯ Night Vision Problems
◯ Sandy/Gritty Feeling
◯ Tired Eyes
◯ Vision Therapy
◯ Other:_____

**Check conditions that are present in *other* family members:**

◯ Cancer Type:_____
◯ Cataracts before age 60
◯ Other *eye* diseases (please list)_____
◯ Other Inherited Conditions (please list)_____
◯ Diabetes
◯ Glaucoma
◯ Heart Disease
◯ High Blood Pressure
◯ High Cholesterol
◯ Macular Degeneration
◯ Stroke/TIA's

## CONTACT LENS HISTORY

**Have you ever worn contacts?** ◯ Yes ◯ No
**When was the last time you wore contacts?**_____
**Are you here for a contact lens prescription today?** ◯ Yes ◯ No
**How many days a month do you sleep in your contacts?**_____

**Please check which kind of contacts you currently wear or are interested in:**

◯ Daily Wear (1 pair for the year)
◯ Extended Wear (can sleep in)
◯ Disposable: How often do you throw each pair away?_____
◯ Rigid Gas Permeable
◯ Bifocal/Monovision
◯ Toric/Astigmatism
◯ Colors
**Problems with contacts:** *(please circle)* dry, uncomfortable, blurry, other
◯ Blurry
◯ Other_____
**Brand of current contacts:**_____
**Solution you currently use:**_____

## SOCIAL HISTORY, HOBBIES & INTERESTS

◯ Indoor/Outdoor Sports
◯ Exercising
◯ Travel/Vacation
◯ Swim
◯ Computers___hrs/day
◯ Musical Instruments
◯ Tobacco Products
◯ Alcohol
◯ Recreational Drug Use
◯ Reading
◯ Other:_____

# V·EYE·P

## NOTICE OF PRIVACY PRACTICES

**HIPAA - Patient Consent for use and disclosure of protected health information**

**I hereby give my consent for V EYE P to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). V EYE P's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. V EYE P reserves the right to revise its Notice of Privacy Practices at anytime. With this consent, V EYE P can call me at home or other alternate locations and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, obtaining insurance information, billing and any calls pertaining to my clinical care. With this consent , V EYE P may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, statements and/or insurance information. By signing this form, I am consenting to V EYE P the use and disclose of my PHI to carry out TPO. My signature below signifies my understanding and willingingess to comply with the above policies.**

***Signature of patient (or guardian)*** ***Date***

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

**When provided the necessary insurance information prior to an appointment, the staff of V EYE P makes every attempt to verify patient's benefits. In addition, the staff will gladly file insurance claims on behalf of the patient. The insurance carrier will review the claim and accept or deny coverage as they deem appropriate. Should the insurance company deny coverage, it is the patient's responsibility to pay any and all of the balance to V EYE P. To be better prepared, patients should attempt to know their coverage including deductibles, co-pays and non-covered services.**

**The staff of V EYE P can give you a general idea of what may or may not be covered by your insurance plan before seeing the doctor. However, we cannot always know for certain what services will be provided by the doctor before the examination.**

**Whether a visit will be filed with a vision carrier or medical carrier is dependent on several factors including but not limited to patient's reason for visit, type of exam performed, and diagnoses. Any diagnosis other than a routine diagnosis will result in a medical claim submittal. At times, patients may be able to use both medical and vision benefits to maximize patients' benefits.**

**By signing below, I acknowledge that I have read and understand the above.**

***Signature of patient (or guardian)*** ***Date***

## SIGNATURE ON FILE

- **I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.**
- **I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.**
- **I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.**
- **I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.**
- **I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR.**
- **I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.**
- **I AUTHORIZE EMAILS & TEXT MESSAGES BE SENT TO ME FOR APPT REMINDERS, ORDER NOTIFICATIONS AND PROMOTIONAL OFFERS & EVENTS.**

***Signature of patient (or guardian)*** ***Date***