EYE SAVERS

We are pleased to welcome you to the office of
Eye Savers/Dr. John Case.

Please take a few moments to complete this questionnaire.

Date SS No. Birthdate Sex ☐ M ☐ F

Last Name First Name MI ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

Address City State Zip

Cell No Work No Home No

Email Preferred method of contact

Occupation Patient's Employer/School

Has any family member/friend been here before? ☐ Y ☐ N If yes, who? Relationship

Who may we thank for referring you?

In case of emergency, contact:

Name Relationship Phone

If patient is a minor please complete the following:

Parent/Guardian Name Relationship Phone

EYE HEALTH HISTORY (I would like to see the doctor today for a/an)

☐ Annual eye health evaluation ☐ Annual contact lens evaluation ☐ Medical Visit ☐ Lasik Consultation ☐ Other

Reason for Visit

Do you wear glasses? ☐ Yes ☐ No If yes, when? ☐ All the time ☐ Occasionally ☐ Reading ☐ Driving ☐ Computer

Do you wear contacts? ☐ Yes ☐ No If yes, what brand?

Describe any problems you have with your contacts

Do you have any eye conditions or problems? ☐ Yes ☐ No If yes, what kind?

Do you have any eye surgeries? ☐ Yes ☐ No If yes, what kind? Date

Do you have any eye injuries? ☐ Yes ☐ No If yes, what kind? Date

Date of last eye exam Doctor's Name

Do you experience (check all that apply) ☐ None ☐ Blurred vision ☐ Headaches ☐ Allergies ☐ Eye Strains/Pain

☐ Sensitivity to Light ☐ Poor Vision at Night ☐ Burning, itchiness, redness, dryness, tearing ☐ Double Vision

☐ Flashes or floaters ☐ Other (please describe)

MEDICAL HISTORY | INCLUDING FAMILY MEDICAL HISTORY

There are several ocular side effects from many of the commonly prescribed oral medications. Please list or provide a copy of ALL your current medications, including oral medications and eye drops.

Do you have problems with any of the following conditions? ☐ None ☐ High Blood Pressure ☐ Diabetes

☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Arthritis ☐ Allergies ☐ Asthma ☐ Cataracts ☐ Glaucoma

☐ Other (please explain):

Allergies to medication? ☐ Yes ☐ No ☐ Which?

Name of family doctor Date of last visit

Other health problems

Does anyone in your family have any of these conditions/diseases? If so, whom?

☐ High Blood Pressure ☐ Macular Degeneration ☐ Diabetes ☐ Retinal Detachment ☐ Glaucoma ☐ Arthritis

☐ Asthma ☐ Heart Disease ☐ Cataracts ☐ High Cholesterol ☐ Cancer ☐ None

EYE SAVERS

WELLNESS TESTING • WELCOME TO THE 21ST CENTURY

In addition to your comprehensive eye examination, we will use new technology to screen for early signs of ocular & systemic diseases such as diabetes, hypertension, glaucoma, macular degeneration, tumors, etc. This new technology includes Digital Retinal Imaging & Computerized Visual Field Analysis. In order to provide you with the most complete exam possible, these tests have now become an essential part of the complete eye health analysis. **The additional fee for this testing is $39.00 and is NOT covered by vision insurance plans.**

☐ I agree to the wellness testing ☐ I would like more information Please Initial _____

INSURANCE *(if you are using insurance, please complete this section. Please have your insurance cards available)*

Policy Holder Name _____ Employer Name _____

Name of Medical Insurance *(for eye injuries, eye diseases or medically related office visits)* _____

Plan ID # _____ Group Name/Number _____

Name of Vision Insurance *(for glasses, contact lenses & wellness exams)* _____

Plan ID # _____ Group Name/Number _____

☐ I request that payment of the authorized insurance benefits be made either to me or on my behalf to Eye Savers for any services furnished to me by Dr. Case. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment, I will be responsible for said services.

FINANCIAL RESPONSIBILITY

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all chargers. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims. Please give any forms to the receptionist. Eye Savers cannot bill insurance after services/products have been rendered.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

☐ I attest that all the information provided on this form is accurate.

Payment for the Doctor visit is required at time of service. Please indicate below how you intend to pay for your visit today. If paying by check we require a valid driver's license or credit card. We accept the following forms of payment (please check selected method):

☐ Cash ☐ Check ☐ Debit Card ☐ MasterCard ☐ Visa ☐ Discover

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

☐ I acknowledge that I have received/reviewed the Notice of Privacy (**www.eyesaversorangecity.com/privacy-policy**)

EMAIL CONSENT

☐ General communication thru email such as records requests or prescriptions, are not encrypted (not secure) and can be accessed by third parties. Because email is a very popular and convenient way to communicate, I understand the risks and do hereby give this office permission to send my personal health information via unencrypted email if I choose.

SIGNATURE

By signing below, I understand my rights and obligations related to:
1) Vision and Medical Insurance 2) Financial Responsibility 3) **HIPAA Privacy Practice Rules** 4) Email Consent

Print Name _____ Signature _____ Date _____