theeyestudio
A Vision Wellness Experience

Welcome to our office! Please take a moment to complete the information below so we can better serve you.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Male ☐ Female

First Name: _____ Last Name: _____

Preferred Name: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____ /_____ /_____

Guardian/Guarantor: _____

Email Address: _____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

May we contact you through E-Mail? ☐ Yes ☐ No

Would you like appt. reminders/recalls via texting? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

How were you referred to our office? _____

Referred by? _____

INSURANCE INFORMATION

Vision Insurance Company: _____

Medical Insurance Company:_____

Insured's ID Number:_____ Group Number: _____

Insured's Date of Birth: _____ /_____ /_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Status: ☐ Single ☐ Married ☐ Other ☐ Student ☐ Employed

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Name: _____

PATIENT HISTORY AND INFORMATION

What is the main reason for your visit today? _____

Last Medical / Primary Care Exam date: _____ /_____ /_____

Primary Care / Internal Doctor's Name: _____

Past Illnesses or Injuries: ☐ Yes ☐ No

If yes, please list: _____

Past Surgeries: ☐ Yes ☐ No

If yes, please list: _____

Current Medications and Dosages: _____

_____

Current Eye Drops: _____

_____

Allergies to Medications? ☐ Yes ☐ No

If yes, please list: _____

Other Allergies (seasonal / food): _____

Would you like to discuss? ☐ Lasik/PRK
☐ Overnight Corneal Reshaping (OrthoK) lenses
☐ New Contact lenses
☐ Sport eyewear
☐ Computer glasses

Other: _____

Name: _____

EYE/GENERAL HEALTH HISTORY

Cataract	☐ yes	☐ no	Ear, Nose, Throat	☐ yes	☐ no	If yes, please list:	
Macular Degeneration	☐ yes	☐ no	Neurological	☐ yes	☐ no	If yes, please list:	
Glaucoma	☐ yes	☐ no	Other Symptoms	☐ yes	☐ no	If yes, please list:	
Diabetes	☐ yes	☐ no	Psychiatric	☐ yes	☐ no	If yes, please list:	
Diabetic Retinopathy	☐ yes	☐ no	Cardiovascular	☐ yes	☐ no	If yes, please list:	
Dry Eyes	☐ yes	☐ no	Respiratory	☐ yes	☐ no	If yes, please list:	
Eye infection	☐ yes	☐ no	Gastrointestinal	☐ yes	☐ no	If yes, please list:	
Eye Inflammation or allergy	☐ yes	☐ no	Genitourinary	☐ yes	☐ no	If yes, please list:	
Floaters and/or Flashes of light	☐ yes	☐ no	Musculoskeletal	☐ yes	☐ no	If yes, please list:	
Iritis or Uveitis	☐ yes	☐ no	Skin	☐ yes	☐ no	If yes, please list:	
Retinal defects or degeneration	☐ yes	☐ no	Thyroid/Diabetes	☐ yes	☐ no	If yes, please list:	
Redness	☐ yes	☐ no	Blood/Lymph	☐ yes	☐ no	If yes, please list:	
Burning	☐ yes	☐ no	Allergy/Immune	☐ yes	☐ no	I f yes, please list:	
Itching	☐ yes	☐ no	Pregnant	☐ yes	☐ no		
Tearing	☐ yes	☐ no	Nursing	☐ yes	☐ no		
Discharge	☐ yes	☐ no	Amblyopia (Lazy Eye)	☐ yes	☐ no		
Blurred Vision	☐ yes	☐ no	Strabismus	☐ yes	☐ no		
Eyestrain	☐ yes	☐ no	Retinal Detachment	☐ yes	☐ no		
Eye Pain	☐ yes	☐ no	Nystagmus	☐ yes	☐ no		
Severe sensitivity to lights	☐ yes	☐ no					
Headache	☐ yes	☐ no	Alcohol	☐ yes	☐ no	I f yes, amount per week:	
Poor night vision	☐ yes	☐ no	Smoke	☐ yes	☐ no	Previous smoker? ☐ yes ☐ no	
Bothersome night glare	☐ yes	☐ no	Tobacco	☐ yes	☐ no	I f yes, please list:	
Double Vision	☐ yes	☐ no					
Total loss of vision	☐ yes	☐ no					

FAMILY HISTORY

Cataract	☐ yes	☐ no	Strabismus	☐ yes	☐ no	Cancer ☐ yes ☐ no	
Glaucoma Suspect	☐ yes	☐ no	Retinal Detachment	☐ yes	☐ no		
Glaucoma	☐ yes	☐ no	Dry Eye	☐ yes	☐ no		
Macular Degeneration	☐ yes	☐ no	Nystagmus	☐ yes	☐ no		
Amblyopia (lazy eye)	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no		
Severe Near/Farsightedness	☐ yes	☐ no	Diabetes	☐ yes	☐ no		

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Explanation of Contact Lens Evaluation Fees

An annual routine eye exam includes glaucoma screening, dilation, refraction (to obtain your glasses prescription), and overall eye health evaluation. If you are a contact lens wearer, our doctors can also evaluate your contact lenses and write a contact lens prescription at your routine eye exam appointment. The contact lens evaluation is a separate fee, and most insurance companies do not fully cover the contact lens evaluation portion of the exam.

A contact lens evaluation is required each year in order to maintain a valid prescription. We offer routine contact lens checks as needed at no charge for 3 months following your exam. After that time period, there may be a charge associated with a contact lens appointment.

☐ Yes, I would like a contact lens evaluation today in order to update my contact lens prescription and have the ability to purchase contact lenses for the next 12 months. I understand that the evaluation fee must be paid at the time of service.

☐ No, I do not want a contact lens evaluation today, and I understand that I will not be able to purchase contact lenses without an updated contact lens prescription.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Eye Studio, PC's notice of Privacy Practices.

Signature_____Date_____

BILLING POLICY

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 60 days old are subject to a $35 late fee. There will be a $25 service charge on all returned checks. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:
1. Routine Vision Plans
2. Medical Insurance

Vision care plans only cover routine vision exams along with eyeglasses or contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnostics, management or treatment of eye diseases.

Medical insurance MUST be used if you have any health problems or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket costs.

We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, copays or non-covered services as allowed by the insurance contract.

APPOINTMENT CANCELLATION POLICY

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel or reschedule your appointment by phone or e-mail a minimum of 24 hours in advance. That way the open slot can be filled with someone needing an appointment.

If you do not cancel by the deadline, you will be assessed a $30.00 missed appointment fee. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated as we institute this new policy.

I have read and agree to the above billing and appointment cancellation policies.

Signature_____ Date_____