



PATIENT INFORMATION:

DATE: _____

First Name: _____ Last Name: _____ Preferred Name: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____ Sex: Male Female Pronoun(s): _____
Date of Birth: _____ Age: ____ Email Address: _____ Can we send you updates? Y N
Occupation: _____ Employer: _____
Marital Status: Single / Married / Divorced / Widowed Do you? (check all that apply) Smoke ____ Drink ____ Use Recreational Meds ____
Primary Care Doctor: _____ Date of Last Visit: _____ Date of Last Eye Exam: _____
Emergency Contact: _____ Phone #: _____

INSURANCE INFORMATION: No Vision Insurance

Vision Insurance Provider: _____ Member ID #: _____
Medical Insurance Provider: _____ Member ID #: _____
Policy Holder: _____ Policy Holder's Date of Birth: _____ Policy Holder's Last 4 SSN: _____

What is your primary reason for visiting us today?: _____

Are you interested in Contact lenses?: Y N Have you previously worn contacts?: Y N If yes, what brand do you use?: _____
Do you use a computer during your day?: Y N How many hours?: _____ Do you have strain while using the computer?: Y N
Do you suffer from dry eye (gritty, burning, watery, etc.) while on the computer or any other time of the day?: Y N
Are you interested in LASIK and other refractive surgeries?: Y N Hobbies/Special visual needs: _____

PATIENT'S MEDICAL HISTORY: (check all that apply) No Known Medical History ____ Pregnant/Nursing (circle one)

Diabetes: Type I ____ Type II ____	How long Diabetic? _____	Last a1c reading?: _____	Blindness	_____
High Blood Pressure ____	Ear/Nose/Mouth ____	Muscle/Joint ____	Retinal Detachment	_____
Asthma/COPD ____	Heart Attack ____	Anxiety/Depression ____	Lazy Eye/Eye Turn	_____
Gastrointestinal ____	HIV/AIDS ____	Seizures ____	Eye Trauma	_____
Neurological ____	High Cholesterol ____	Glaucoma ____	Flashes/Floaters	_____
Thyroid ____	Cancer ____	Cataracts ____	Itchy Eyes	_____
Stroke ____	Headaches/Migraines ____	Macular Degeneration ____	Seasonal Allergies	_____

Past Surgeries / When?: _____

Current Medications: _____

Are you allergic to any medications? Y N If yes, list: _____

FAMILY MEDICAL HISTORY: (check all that apply) No Known Medical History ____

Diabetes ____	Thyroid ____	Cancer ____	Glaucoma	_____
High Blood Pressure ____	Stroke ____	Headaches/Migraines ____	Cataracts	_____
Asthma/COPD ____	Ear/Nose/Mouth ____	Muscle/Joint ____	Macular Degeneration	_____
Gastrointestinal ____	Heart Attack ____	Anxiety/Depression ____	Retinal Detachment	_____
Neurological ____	High Cholesterol ____	Blindness ____	Lazy Eye/Eye Turn	_____

PLEASE CONTINUE TO BACK

HIPAA POLICY/DISCLAIMER:

I have read and understand the HIPAA policy (effective April 14, 2003) presented before me. I understand that all information and correspondence regarding my health care will remain confidential. I am fully responsible for any and all follow up care that may be recommended by the health care professional.

Patient signature: _____ **Date:** _____

RECORDS RELEASE DISCLAIMER:

I hereby authorize the digital transmission of my records by Accuvision Eye Care.

Patient signature: _____ **Date:** _____

INSURANCE DISCLAIMER:

Thank you for choosing Accuvision Eye Care. We really appreciate your business! Because we accept a wide variety of insurance plans with many restrictions imposed by the insurance companies, we want to make sure you understand your responsibilities as an insurance-based customer. We will make our best effort to work with your insurance plan.

You are responsible for:

- ✓ Confirming that you are currently eligible for the insurance benefits
- ✓ Providing us with the most current information about your vision coverage
- ✓ Informing us of any co-payments that you are required to pay

The provisions of your insurance policy may change from one date of service to the next. Please make sure that you are aware of changes so that you can maximize your current benefits. Your insurance company can assist with this.

Sometimes, following an examination, an insurance carrier may not reimburse us for the expected amount (e.g. because you are no longer covered or because you purchased a non-covered item/service). If this happens, you will be responsible for the unpaid balance. This will be billed directly to you.

We apologize that the complexities of vision insurance makes it necessary for you to confirm your understanding of this policy. Your signature below indicates that you understand and comply with our Customer Responsibility Policy. Thank you for giving us the opportunity to satisfy your eye care needs.

Patient signature: _____ **Date:** _____

REFUNDS WILL NOT BE GIVEN FOR SERVICES RENDERED.

WE ALLOW 90 DAYS FOR YOU TO RETURN TO OUR OFFICE IF YOU ARE NOT SATISFIED FOR A RECHECK.

A 2.99% PROCESSING FEE WILL BE CHARGED FOR ALL CARD TRANSACTIONS. TO AVOID THIS FEE, WE ACCEPT CASH PAYMENT.



Optos Retinal Screening Images Notice & Office Policy

At Accuvision Eye Care, we are committed to providing the highest standard of comprehensive eye care. Retinal Imaging will be included in every annual routine eye examination where available.

The fee for Optos retinal screening images is **\$39** and is due at the time of service. This fee may not be covered by routine vision plans or insurance.

Optos retinal screening images provide a wide-field digital view of the retina and assist our doctors in the detection, documentation, and monitoring of eye diseases and systemic health conditions, including glaucoma, retinal tears, macular degeneration, diabetes, hypertension, and other retinal abnormalities.

Benefits of Optos Retinal Screening Images

- Permanent visual documentation of your retinal health for future comparison, monitoring, education, and early disease detection.
- Improved efficiency by reducing examination time and, in many cases, decreasing the need for dilation and the associated waiting period.
- Greater comfort and convenience by limiting close working distances during the retinal evaluation process.
- Reduced side effects commonly associated with dilation, including light sensitivity, blurred near vision, and temporary driving difficulties.

In many cases, Optos retinal screening images may reduce or eliminate the need for dilation; however, dilation may still be required at the doctor's discretion depending on your ocular health findings, symptoms, medical history, or quality of images obtained.

By signing below, I acknowledge that I have read and understand the Optos retinal screening images policy and understand that this is a component of my routine annual eye examination at Accuvision Eye Care.

Patient Name: _____

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if minor): _____

Relationship to Patient: _____