Welcome to EyeCare Plus!

Please bring the completed forms with you to your appointment.

Patient's Name:_____ ☐Male ☐Female

Nickname:_____DOB:_____SSN: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Occupation:_____Work Phone: _____

Email:_____Cell Phone: _____

Emergency Contact:_____ Phone: _____

Communication Preferences:

Do we have permission to send glasses and/or contact lens prescriptions to the e-mail provided above? ☐Yes☐No

May our office leave a detailed message at the phone number above? ☐Yes ☐No

Would you like to receive appointment reminders by text message? ☐Yes ☐No

Do you want to activate your patient portal? ☐Yes ☐No

Permission to share or discuss your medical information:

☐ **No**, I do NOT want my information shared with anyone other than my PCP and referred providers.

☐ **Yes**, you may share my information with the following individuals.

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Signature:_____Date: _____

Insurance Information:

Vision Insurance Carrier:_____ID#_____

Subscriber's Name:_____DOB:_____

Medical Insurance Carrier:_____ID#_____Group#_____

Subscriber's Name:_____DOB: _____

Secondary Insurance Carrier:_____ID#_____Group#_____

Subscriber's Name:_____DOB: _____

PCP:_____**Phone:**_____**City**:_____

Specialist: _____**Phone:**_____**City**:_____

Pharmacy:_____**Phone:**_____**City**:_____

MEDICAL HISTORY: *Do you have?*

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐History of Cancer
☐Osteoporosis ☐COPD/Emphysema ☐Thyroid Disease ☐History of Stroke
☐Arthritis ☐Asthma ☐Sjogren's Syndrome ☐Heart Disease

Other:_____

OCULAR HISTORY: *Do you have?*

☐Glasses ☐Contact lenses ☐Dry Eyes ☐Ocular allergies ☐Amblyopia "Lazy eye"
☐Cataracts ☐Keratoconus ☐Glaucoma ☐Macular Degeneration ☐Diabetic Retinopathy

☐Other diagnosed eye disease or disorder:_____

OCULAR SURGERY: *Have you had?*

☐LASIK - PRK -RK Eye:☐R☐L Date:_____Surgeon: _____
☐Cataract surgery Eye:☐R☐L Date:_____Surgeon: _____
☐Retina surgery Eye:☐R☐L Date:_____Surgeon: _____
☐Glaucoma surgery Eye:☐R☐L Date:_____Surgeon: _____
☐Other: _____

MEDICATIONS: Please list <u>all</u> medication below. (*Many prescription drugs may cause ocular side effects.)*

☐I do not take any medication. ☐Medication list attached

_____

_____

ALLERGIES:_____

What is your smoking status? ☐Never a smoker ☐Former smoker ☐Current smoker
Do you consume alcohol? ☐Never ☐Occasionally ☐More than 1 drink per day
FEMALES: Are you pregnant or nursing? ☐Yes ☐No

FAMILY HISTORY:

☐Glaucoma ☐Macular Degeneration ☐Retinal Detachment ☐Ocular Melanoma ☐Retinitis Pigmentosa

☐Other_____

Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. A copy of the full-length notice may be obtained at the front desk or our website. This notice describes how medical information about you may be used and disclosed and how you may access this information. You have certain rights regarding the information we maintain about you. All requests must be made in writing. These rights include: the right to inspect and copy medical records (fees apply, federal regulations allow 30 days for completion); the right to amend; the right to a paper copy of this notice; the right to request restrictions; the right to request confidential communication. Examples of how we use and disclose your information include: medical treatment, emergency situations, worker's compensation programs, to obtain payment for our services from your insurance, appointment reminders, research and to run our practice more efficiently.

Assignment of Benefits

I request that payment of authorized insurance benefits (Medicare, commercial or vision insurance) be made to EyeCare Plus for any services rendered to me. I authorize release of medical information necessary to process insurance claims to determine payment for the related services. I understand that I am financially responsible for the deductible, co-insurance and non-covered services.

Financial & Managed Care Policies (Including Medicare)

Your insurance only pays for covered benefits. Some items and services are NOT covered benefits and your insurance will NOT pay for them. You are responsible to pay for uncovered benefits, personally or through any other insurance that you may have.

Your plan may NOT cover the following:

- -Professional contact lens evaluation/fees (May only be covered or discounted by VISION insurance plans)
- -Routine eye examinations
- -Refraction (A test that determines your glasses prescription and measure your best corrected vision)

I understand that I am responsible for any fees or services that are not covered by my insurance company AND that payment will be collected at the time of service.

I understand that I may receive a bill for services rendered and I have the right to appeal denied claims with my insurance company.

Signature:_____**Date:**_____

Thank you for choosing EyeCare Plus for your family eye care!