



**PATIENT INFORMATION AND MEDICAL HISTORY**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_  
SOCIAL SECURITY#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE or FEMALE  
HOME ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ CELL/WORK PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
EMPLOYER/SCHOOL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PRIMARY CARE PHYSICIAN: \_\_\_\_\_ CITY: \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PHONE #: \_\_\_\_\_

Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please supply information for both carriers.

**INSURANCE INFORMATION**

PRIMARY INS CO: _____	SECONDARY INS CO: _____
INSURED: _____	INSURED: _____
RELATIONSHIP TO PATIENT: _____	RELATIONSHIP TO PATIENT: _____
INSURED ID #: _____	INSURED ID #: _____
INSURED BIRTHDATE: _____	INSURED BIRTHDATE: _____
INSURED SS#: _____ - _____ - _____	INSURED SS#: _____ - _____ - _____
GROUP #: _____	GROUP #: _____
EMPLOYER: _____	EMPLOYER: _____

# EYECARE 20/20

## OFFICE POLICY, FINANCIAL ASSIGNMENT AND AGREEMENT:

### READ CAREFULLY AND SIGN

- 1. PAYMENT IS EXPECTED AT EACH VISIT.** If we are a participating provider for your health plan we will file health insurance claims for you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.  
**You will be responsible for paying any co-payments, coinsurance, deductibles and non-covered services at the time of the visit.** Final payment responsibility will be determined upon receipt of correspondence from your insurance company.  
If we are NOT a participating provider for your health plan, you will be expected to pay in full at the time of the visit. You are responsible for filing your insurance claims.
2. To avoid any potential misunderstandings, advise the receptionist should you need to make financial arrangements.
3. Patient statements will be mailed monthly. If no payments are received on account after 3 billing cycles, collection procedures will commence.
4. There will be a \$20.00 charge on all checks returned unpaid due to insufficient funds.
5. All outstanding balances due by the patient must be paid before scheduling additional visits.
6. This office is **NOT** responsible for collecting on your insurance claim nor for settling a disputed claim. Misunderstandings over insurance coverage and policy benefits are a matter to be resolved between the patient and their insurance company. We do not balance accounts according to "Reasonable and Customary" allowances established by insurance companies that we are not contracted with. Our services are coded according to the guidelines established by the AMA's Current Procedural Terminology (CPT). We will not code for reimbursement based on your insurance coverage.
7. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
8. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THIS POLICY AND AGREEMENT.**

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**Patient or Authorized Signature**

**Patient's Name Printed**

**Date signed**

### **PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I understand that as part of the provision of healthcare services, EyeCare 20/20 creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing below, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

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**Patient or Authorized Signature**

**Patient's Name Printed**

**Date signed**

# EYECARE 20/20

## EYE AND MEDICAL HISTORY

1. What is the **reason for your visit** today? \_\_\_\_\_

2. Are you currently experiencing any of the following **eye symptoms**? Please circle all that apply.

<b>Eye Pain</b>	<b>Blurred Vision</b>	<b>Eyelid Crusting</b>	<b>Flashes of Light</b>	<b>Halos</b>
<b>Discharge</b>	<b>Light Sensitivity</b>	<b>Double Vision</b>	<b>Decreased Vision</b>	<b>Floaters</b>

3. Do you wear glasses?                      Yes      No

4. Do you wear contact lenses?            Yes      No

5. Do you have problems reading?        Yes      No

6. Have you ever had an **eye injury**? If yes, please describe: \_\_\_\_\_

7. Have you ever had **eye surgery**? If yes, please list the type, which eye and the approximate dates.

8. Do you have a **family history** of any of the following eye problems? Please circle and list family relationship.

<b>Glaucoma</b>	<b>Cataracts</b>	<b>Retinal Disease</b>	<b>Macular Degeneration</b>
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9. Are you currently using any **eye medications**? If yes, please list the name and how often used. \_\_\_\_\_

10. What **medications** other than above are you taking? Please list. \_\_\_\_\_

11. Are you **allergic** to any medications? If yes, please list. \_\_\_\_\_

12. Are you being treated for any of the following medical conditions? Please circle all that apply.

<b>Diabetes</b>	<b>Heart Disease</b>	<b>High Blood Pressure</b>	<b>Stroke</b>	<b>Arthritis</b>	<b>Other</b>	_____
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Do you currently have any of the following **problems**: Please circle **Yes** or **No** and If Yes, please explain.

<b>Chronic fever, unexpected weight loss/gain, fatigue?</b>	Yes	No	_____
<b>Ear, nose, throat problems (hearing loss, sinus problems, sore throat)?</b>	Yes	No	_____
<b>Heart problems (chest pain, irregular heart beat)?</b>	Yes	No	_____
<b>Respiratory problems (shortness of breath, wheezing, coughing)?</b>	Yes	No	_____
<b>Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)?</b>	Yes	No	_____
<b>Urinal problems (pain or discomfort, blood in urine)?</b>	Yes	No	_____
<b>Skin problems (rashes, excessive dryness)?</b>	Yes	No	_____
<b>Musculoskeletal problems (muscle aches, joint pain, swollen joints)?</b>	Yes	No	_____
<b>Neurologic problems (numbness, weakness, headaches, paralysis)?</b>	Yes	No	_____
<b>Psychiatric problems (depression, anxiety)?</b>	Yes	No	_____

Do you smoke? \_\_\_\_\_ If Yes, how much? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

If employed, how many hours per week do you work? \_\_\_\_\_ hours

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_