

# Accuvision Eye Care O.D., P.A.

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

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Sex: Male Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_ Can we email you updates/specials? Y / N

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Social Security # \_\_\_\_\_ Insurance Provider \_\_\_\_\_

Policy Holder \_\_\_\_\_ Holder's Date of Birth \_\_\_\_\_ Policy/Member # \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Last Visit? \_\_\_\_\_ Last Eye Exam? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Marital Status: Single / Married / Divorced / Widowed Do you? Smoke \_\_\_ Drink \_\_\_ Recreational Meds \_\_\_

Hobbies/Special visual needs \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Do you wear contacts? Brand? \_\_\_\_\_ Are you interested in contact lenses? \_\_\_\_\_

Do you use a computer during your day? \_\_\_\_\_ Hrs/day \_\_\_\_\_ Strain while using computer? \_\_\_\_\_

Are you interested in learning about LASIK and other refractive surgeries? \_\_\_\_\_

What is your primary reason for visiting us today? \_\_\_\_\_

**MEDICAL INFORMATION:** Check if you or anyone in your immediate family has any of the following:

	Self	Family		Self	Family
High Blood Pressure	___	___	Dry Eye	___	___
Diabetes	___	___	Eye Trauma	___	___
Asthma/COPD	___	___	Flashes/Floaters	___	___
Gastrointestinal	___	___	Glaucoma	___	___
Neurological	___	___	Cancer	___	___
Thyroid	___	___	Lazy Eye/Eye Turn	___	___
Muscle/Joint	___	___	Blindness	___	___
High Cholesterol	___	___	Retinal Detachment	___	___
Stroke	___	___	Cataracts	___	___
Ear/Nose/Mouth	___	___	Macular Degeneration	___	___
Anxiety/Depression	___	___	Itchy Eyes	___	___
Heart Attack	___	___	Seasonal Allergies	___	___
HIV/ AIDS	___	___	Headaches/Migraines	___	___

Past Surgeries / When? \_\_\_\_\_ Pregnant/Nursing \_\_\_\_\_

Current Medications \_\_\_\_\_

Are you allergic to any Medications? \_\_\_\_\_

**PLEASE CONTINUE TO BACK**



ultra-wide digital retinal imaging

Benefits of optomap retinal imaging:

- ✓ NO dilation drops needed (drops make you light sensitive and can blur vision up to 8 hours)
✓ Best standard of care for you and your family
✓ Help detect sight-threatening diseases such as macular degeneration, glaucoma and retinal detachments
✓ Aids in discovering systemic health problems like high blood pressure, diabetes, stroke, and even cancer
✓ Painless, quick and thorough (95% of retina in 1/4 of a second)
✓ Permanent digital images can be referred to in the future, which helps monitor changes
✓ Quicker examination

Like most advanced medical technologies, insurance does not cover this image of the retina. However, we offer it to all Accuvision Eye Care patients for the low cost of \$20.

Please check one and sign below:

- \_\_\_\_\_ I elect to have the optomap retinal imaging for only \$20
\_\_\_\_\_ I decline the optomap and accept dilation if necessary
\_\_\_\_\_ I decline optomap and dilation, knowing the benefits of both

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 \_\_\_\_\_

INSURANCE DISCLAIMER

Thank you for choosing Accuvision Eye Care inside EyeMart Express. We really appreciate your business! Because we accept a wide variety of insurance plans with many kinds of 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 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 \_\_\_\_\_

Please note: There will be an additional \$20.00 fee for all returned checks.