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? _____

<u>MEDICAL INFORMATION</u>: 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

optomap®
ultra-wide digital retinal imaging

Benefits of optomap retinal imaging:

- ✓ NO dilation drops needed (dilation 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 ¼ 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 Walmart. 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.