ACCUVISION
EYE CARE O.D.,P.A.

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 #: _____

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: _____

INSURANCE INFORMATION:

Vision Insurance Provider: _____ Member ID #: _____

Medical Insurance Provider: _____ Member ID #: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____ Policy Holder's Last 4 SSN: _____

PATIENT'S MEDICAL HISTORY: (check all that apply) No Known Medical History ___

Diabetes: Type I ___ Type II ___ How long Diabetic? _____ Last a1c reading?: _____ Pregnant/Nursing (circle one)

High Blood Pressure	___	Ear/Nose/Mouth	___	Muscle/Joint	___	Retinal Detachment	___
Asthma/COPD	___	Heart Attack	___	Anxiety/Depression	___	Lazy Eye/Eye Turn	___
Gastrointestinal	___	HIV/AIDS	___	Blindness	___	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

optomap®
ultra-wide digital retinal imaging

BENEFITS OF THE OPTOMAP RETINAL IMAGING:

- √ NO dilation drops needed, NO light sensitivity, NO blurred vision
- √ Best standard care for you and your family
- √ Help detect sight-threathening diseases such as macular degeneration, glaucoma and retinal detachments
- √ Aids in discovering systemic health problems such as high blood pressure, diabetes, stroke, and even cancer
- √ Painless | Quick | Thorough: 95% of the retina is photographed 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, insurances does not cover this image of the retina.

However, we offer it to all Accuvision Eye Care patients for the low cost of $29.

Please check one and sign below:

____ I elect to have the optomap retinal imaging for only $29

____ I decline the optomap, and accept dilation if necessary

____ I decline the 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. 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.