Patient Information

Name____Date________ SS______________

Address____________________________________City______________State________Zip_________

Birthdate______________________ M [ ] F [ ] **E-Mail**___________________________________ [ ]

Home Phone___________________Cell____________________Work_________________________

Please check your contact preference: [ ] [ ] [ ]

[ ] Married [ ] Widowed [ ] Single [ ] Separated [ ] Divorced [ ] Partnered for_____years

Primary Language ______________________ Race _____________ Ethnicity ______________________

Patient Employer/School______________________________Occupation_____________________

Referred by:____

Responsible Party

Name of Person responsible for this account____

Address_______________________________City______________State________Zip_______________

Phone_________________________Relationship to patient______________________________________

Primary Care Doctor_____________________________________**Phone**_____________________

Pharmacy____**E-Rx** [ ]

Insurance Information

Name of insured_________________________________Relationship to patient_________________

Birth date______________SS____________________Employer___________________________

Insurance Co.______________________ID #_______________________Group____________

DO YOU HAVE ADDITIONAL INSURANCE? [ ] No [ ] Yes If yes, please complete the following:

Name of insured_________________________________Relationship to patient_________________

Birth date______________SS____________________Employer___________________________

Insurance Co.______________________ID #_______________________Group____________

CO-PAYMENTS ARE DUE AT TIME OF SERVICE.

MEDICARE DOES NOT PAY FOR REFRACTION (EYE TEST) – THIS IS YOUR RESPONSIBILITY ($40). PRIVATE INSURANCE MAY OR MAY NOT COVER REFRACTION. IF THIS IS NOT COVERED, YOU WILL BE RESPONSIBLE ($40).

ANY CO-INSURANCE (MEDICARE 20%) WILL BE THE PATIENT'S RESPONSIBILITY.

IF YOU HAVE MEDICAL INSURANCE COVERAGE ONLY AND YOUR COMPLAINTS ARE NOT OF A MEDICAL NATURE, YOUR VISIT WILL NOT BE COVERED AND YOU WILL BE RESPONSIBLE FOR CHARGES.

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL FOR THIS VISIT, IT IS YOUR RESPONSIBILITY TO HAVE THE REFERRAL AT TIME OF SERVICE, OTHERWISE YOU WILL BE CHARGED FOR THE EXAMINATION.

ANY PROCEDURES/TESTS THAT ARE NOT COVERED OR DENIED BY YOUR INSURANCE CARRIER WILL BE YOUR RESPONSIBILITY.

RESIDENT EYE CARE ASSOCIATES

PRE-TESTING QUESTIONARE

Name____ Date _________________________

1. Who is your Primary Doctor? ____ When was your last visit?_____________________ Was this a well visit? _____ If no, reason _____________
2. Who was your last eye doctor? ____________________________________

   When was your last eye exam? ____________________

3. What health conditions do you have?______________________________________

   ____

   ____

4. What medications do you take? ____

   ____

5. What medications are you allergic to? _______________________________________
6. Do you have any eye conditions? ____
7. Do you have any family history of the following conditions and if so which family member?
   a. Glaucoma ______________________
   b. Cataracts ______________________
   c. Macular Degeneration ______________________
   d. Diabetes________________________________
   e. Cancer__________________________________
   f. Heart Disease _____________________________
8. Do you smoke ? _____ How many packs a day? _________
9. Do you drink? ____Wine/Liquor/Beer_____ How many times a week?
10. Do you use a computer every day ?_____ How many hours a day?______

CHIEF COMPLAINT

Reason for today's exam____

____

Please check any of the following that apply to you:

[ ] Frequent headaches [ ] Sinus problems [ ] Pregnant [ ] Given birth last 6 months

[ ] Smoking [ ] Drinking [ ] Weight gain/loss [ ] Exercise

Previous eye doctor________________________________Date of last exam__________

Present Medications: ____

____

Have you ever had any of the following conditions involving your **eyes**?

[ ] Eye surgery [ ] Eye injury [ ] Medical treatment [ ] Severe pain [ ] Eye strain

[ ] Double vision [ ] Burn, itch, water [ ] Floaters or spots [ ] Sensitive to light

[ ] Infection or disease [ ] Poor distance vision [ ] Poor near vision

Do you currently wear glasses? [ ] Yes [ ] No

When do you wear your glasses?

[ ] All the time [ ] Distance tasks [ ] Reading/near work [ ] Work safety [ ] Computer

[ ] Other, please explain____

Are you planning on getting new glasses? [ ] Yes [ ] No

Have you ever worn contact lenses? [ ] Yes [ ] No

Are you interested in wearing contact lenses? [ ] Yes [ ] No

What hobbies or sports do you participate in?________________________________

Do you or anyone in your immediate family have a history of the following?

[ ] Diabetes [ ] High blood pressure [ ] Thyroid [ ] Heart Condition

[ ] Respiratory [ ] Gastrointestinal [ ] Neurological [ ] Musculoskeletal

[ ] Psychiatric [ ] Hematological [ ] Cataracts [ ] Glaucoma [ ] Blindness

[ ] Turned or "lazy" eye [ ] Allergies (please list):______________________________

____

Consent for Treatment, Certification and Assignment

I consent to necessary treatment including drugs, medicine, performance of in-office procedures or other studies and tests that may be used by the doctors and staff.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with______________________________ and assign directly to Resident Eye Care Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

[ ] I authorize Resident Eye Care Associates to keep my signature on file and to charge my credit card on record for all remaining balances after insurance claims is/are resolved. This includes co-pays, deductibles, glasses, contact lenses and any denied claims

Resident Eye Care Associates may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

____Date__________________

Signature of Patient, Parent, Guardian or Personal Representative

____Relationship to Patient________________

Please print