PATIENT INFORMATION

Name _____ Date of Birth _____ Date _____
Last First MI

Street Address _____ Email _____

City/State/Zip code _____ ☐ Male ☐ Female (Circle the best phone number to reach you at.)

Phone _____ _____ _____
Home phone Business phone Cell phone

Employer _____ Occupation _____ Referred by? _____ SSN _____

Reason for today's exam _____

_____

_____

Date of last eye exam _____

Name of eye doctor _____

Who is your primary care Doctor? _____

Where is your Doctor located? _____

Do you currently wear glasses? ☐ YES ☐ NO

Are you interested in being fit for contact lenses today? ☐ YES ☐ NO

Have you ever worn contacts? ☐ YES ☐ NO

List any problems with your current contacts _____

_____

What kind of contact lens solution do you use? _____

Have you ever been diagnosed with any of the following?

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic retinopathy
- ☐ Dry eye
- ☐ Floaters and/or flashes of light

Do you have any of the following eye concerns?

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred vision-distance
- ☐ Blurred vision-near
- ☐ Eye strain
- ☐ Eye pain
- ☐ Severe sensitivity to lights
- ☐ Headaches
- ☐ Poor night vision

How long?

_____

_____

_____

Are you using any drops?

_____

_____

Do you or any blood relatives suffer from problems with:

Yes	No		Who? What?
☐	☐	Eyes (Cataracts, Glaucoma, Macular Degeneration)	_____
☐	☐	Constitution (Development Disabilities, Cancer, Fatigue Syndrome)	_____
☐	☐	ENT (Hearing Loss, Sinusitis, Dry Mouth, Laryngitis)	_____
☐	☐	Neuro. (Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Migraine)	_____
☐	☐	Psychiatric (Depression, Attention Deficit, Anxiety, Bipolar Disorder)	_____
☐	☐	Cardiovascular (High Blood Pressure, Heart Disease, Congestive Heart Failure)	_____
☐	☐	Respiratory (Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea)	_____
☐	☐	Gastrointestinal (Crohns, Colitis, Ulcer, Acid Reflux, Celiac Disease)	_____
☐	☐	Genitourinary (Kidney Disease, Prostate Disease/Cancer, STD, Pregnant)	_____
☐	☐	Muscle/skeleton (Arthritis, Fibromyalgia, Muscular Dystrophy, Osteoporosis, Gout)	_____
☐	☐	Integumentary (Eczema, Rosacea, Psoriasis, Cold Sores, Shingles)	_____
☐	☐	Endocrine (Diabetes, Thyroid Dysfunction, Hormonal Dysfunction)	_____
☐	☐	Hem/lymph (Anemia, Ulcer, High Cholesterol, Large Volume Blood Loss)	_____

Please list all medications you are currently taking: _____

_____

_____

Please list all allergies: _____

_____

PLEASE FILL THIS OUT

Routine Vision Insurance

I.D./Group # _____

Insurance Company _____

Name of Insured _____

Insured's birth date _____

Relationship to patient _____

Employer _____

Primary Medical Insurance

I.D./Group # _____

Insurance Company _____

Name of Insured _____

Insured's birth date _____

Relationship to patient _____

Employer _____

Have you ever had any eye diseases, eye infections, or any eye surgeries?

☐ YES ☐ NO Explain _____

_____

_____

How much? How often?

Do you drink? ☐ YES ☐ NO _____

Do you smoke? ☐ YES ☐ NO _____

Secondary Medical Insurance

I.D./Group # _____

Insurance Company _____

Name of Insured _____

Insured's birth date _____

Relationship to patient _____

Employer _____

West Mobile Eyecare
Financial Policy

Thank you for choosing West Mobile Eyecare, LLC as your eye care provider. We are committed to making eye care less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy. We ask that you read and sign this form prior to your office visit.

Your insurance policy is a contract between you and your insurance company. We are not part of that contract, and the patient is solely responsible for services rendered. Should your account be unpaid 45 days following the date of service, and we have not heard from your insurance company, we ask that the patient contact their insurance company to help expedite payment.

*****PLEASE INITIAL BELOW*****

_____ **AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION:**

Initials I authorize West Mobile Eyecare, LLC to disclose any personal health information necessary to process health insurance claims, coordinate or manage treatment, and for the purpose of our healthcare operations. I also authorize payment **DIRECTLY** to West Mobile Eyecare for services rendered.

_____ **ACKNOWLEDGEMENT OF RESPONSIBILITY:**

Initials I understand that I am financially responsible to West Mobile Eyecare, LLC for all professional services rendered, including but not limited to, those services which are not covered by my insurance programs (co-payments and/or deductibles). I also understand that if I have a HMO or PPO insurance and I do not obtain the proper referral authorization prior to my visit, or verify the Optometrist is a preferred provider that I am financially responsible for any charges incurred. I understand the payments for these charges are due at the time of service. In the event of default, I agree to pay all collection cost, including a reasonable attorney fee.

_____ **ACKNOWLEDGEMENT OF "NOTICE OF OUR PRIVACY PRACTICES":**

Initials We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to our form, please ask to speak with our **HIPAA COMPLIANCE OFFICER** in person or by phone at our main phone number.

_____ **APPOINTMENT CANCELLATION POLICY & NO SHOW FEE:**

Initials Our office policy is that an appointment be cancelled with a minimum of two hours prior to the appointed time. We allow a grace period for the first missed appointment; if a second appointment is missed without adhering to our policy your account will be billed **$25.00** and can result in dismissal from our practice.

_____ / _____ / _____

Signature **Printed** **Date**

_____ / _____ (_____)

Date of Birth **Email** **Relationship to patient**

DILATION

It is our goal to provide you a complete comprehensive eye examination. To accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes, which allows a better view of the inside of your eyes.

As with many medications, there are some side affects of the drops used to dilate the pupil. These include: light sensitivity and blurred near vision (in most cases distance vision with be unaffected). The side affects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may wish to refuse this procedure.

_____ I agree to be dilated today if the doctor deems it necessary based on the information I have provided.

Initials

OR

_____ I do not wish to be dilated today and agree to hold the doctor harmless as a result of my actions.

Initials