A Unique Experience

Welcome to AccessorEyes Optometry, we are glad to have you. Please provide us with a thorough history, to the best of your ability, in order to allow the doctor to evaluate the health of your eye completely.

NAME ______________________ SEX _____ AGE _____ DATE OF BIRTH ______________

HOME ADDRESS ____________________ APT ___ CITY ________ STATE ___ ZIP _____ PHONE ________

EMAIL ADDRESS (Print Please) ______________________________

PATIENT SSN: ______________ MARITAL STATUS _______ SPOUSE (parent if minor) ______________

REFERRED BY ________________ RELATIONSHIP TO YOU: Family Coworker Friend Doctor Other

PATIENT EMPLOYED BY ____________________ OCCUPATION ____________________

BUSINESS ADDRESS ______________ CITY __________ ZIP ________ PHONE ___________

MEDICAL INSURANCE: ☐MEDICARE ☐MEDI-MEDI OTHER __________ SECOND INSURANCE ____________

VISION INSURANCE: ☐VSP ☐EYEMED ☐MES ☐ECPA ☐OTHER ______________

INSURED SSN: ______________________ INSURED DATE OF BIRTH ______________

PARTY RESPONSIBLE FOR BILL (if other than patient) ______________________________

ADDRESS ________________ CITY __________ STATE ____ ZIP ________ PHONE ________

NAME OF RELATIVE OR FRIEND IN CASE OF EMERGENCY ______________________________

ADDRESS ________________ CITY __________ STATE ____ ZIP ________ PHONE ________

MEDICAL HISTORY

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (As part of your eye examination, it may be necessary to dilate your pupils. This may hinder your ability to safely drive, and your work may be impaired for up to 8 hours by blurred vision or light sensitivity. If you do not want to be dilated please tell our technician) ______________________________

____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING PROBLEMS WITH YOUR EYES?

☐BLURRED VISION AT A DISTANCE
☐BLURRED VISION AT NEAR
☐ITCHING / BURNING
☐TEARING / DISCHARGE
☐FLOATERS (SPOTS) / FLASHES
☐LIGHT SENSITIVITY
☐VISUAL DISCOMFORT / EYE STRAIN
☐FOREIGN BODY SENSATION
☐OCULAR PAIN
☐DRY EYE
☐HEADACHE
☐REDNESS

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PREVIOUS EYE SURGERY ____________________

ARE YOU INTERESTED IN CONTACT LENSES? ☐YES ☐NO ☐CURRENTLY WEARING CONTACT LENSES

ARE YOU INTERESTED IN COLOR CONTACT LENSES? ☐YES ☐NO ☐CURRENTLY WEARING COLORED CLS

For the health and safety of your eyes, we require annual contact lens evaluation. A separate fee is charged beyond the routine eye exam fee.

ARE YOU INTERESTED IN LASER VISION CORRECTION? ☐YES ☐NO

ARE YOU INTERESTED IN COSMETIC SURGERY, BOTOX? ☐YES ☐NO

ARE YOU INTERESTED IN KNOWING ABOUT THE BENEFITS OF NUTRITIONAL SUPPLEMENTS? ☐YES ☐NO

PLEASE CHECK ILLNESSES YOU HAVE HAD:

☐ALLERGIES	☐DIABETES	☐RHEUMATOID ARTHRITIS	☐CATARACT
☐ASTHMA	☐HEART DISEASE	☐STROKE	☐GLAUCOMA
☐BLEEDING DISORDER	☐HIGH BLOOD PRESSURE	☐THYROID DYSFUNCTION	☐CANCER
☐HIV / AIDS	☐NERVOUS DISORDER	☐ MACULAR DEGENERATION	☐OTHER

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Detail
EYES (poor vision, eye pain, tearing, redness, etc.)	☐	☐	________
GENERAL/CONSTITUTIONAL (fever, weight loss, weight gain, etc.)	☐	☐	________
EARS, NOSE, THROAT (hard of hearing, stuffy nose, dry mouth, etc.)	☐	☐	________
RESPIRATORY (congestion, wheezing, short of breath, etc.)	☐	☐	________
GASTROINTERSTINAL (stomach upset, diarrhea, hernia, ulcers, etc.)	☐	☐	________
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, etc.)	☐	☐	________
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, arthritis, etc.)	☐	☐	________
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	________
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	☐	☐	________
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☐	________
BLOOD/LYMPH (bleeding, high cholesterol, **Hepatitis, HIV**, etc.)	☐	☐	________
FEMALES: Are you pregnant? Nursing?	☐	☐	________

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? YES NO If, YES, how much? ____________________

DO YOU SMOKE? YES NO If, YES, how much? ____________________

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

DISEASES THAT RUN IN YOUR FAMILY ____________________

☐DIABETES	☐HYPERTENSION	☐ARTHRITIS	☐MACULAR DEGENERATION	
☐HEART DISEASE	☐THYROID DYSFUNCTION	☐CHOLESTEROL	☐CATARACT	☐OTHER
☐STROKE	☐CANCER	☐BLINDNESS	☐GLAUCOMA	

WHO IS YOUR PRIMARY CARE PHYSICIAN?____

ADDRESS____________________________ CITY________________ STATE_____ ZIP__________ PHONE______________

EYE MEDICATION(S) YOU ARE TAKING: ____

GENERAL MEDICATION(S): ____

NUTRITIONAL SUPPLEMENT(S): ____

LIST ANY MEDICATION(S) YOU MAY BE ALLERIGIC TO: ____

LIST ANY SURGERIES (INCLUDING EYES):____

1. **EYEGLASS EVALUATION (REFRACTION):** This is the measurement of your eyes to evaluate if you need eyeglasses. If you are already wearing eyeglasses, we will evaluate the need for any changes in your current prescription. Vision insurance plans (ex. Vision Service Plan/VSP) cover this service, usually once a year. Medical insurance plans, such as Medicare, do not cover this service. There is a **$55.00** fee for this service.
_____ I want my eyeglass prescription checked today.

2. **DIGITAL RETINAL PHOTOGRAPHY & OCT :** Our highly sophisticated computerized camera allows us to provide you with a more thorough medical analysis of your eyes. This assists in early detection of macular degeneration, diabetic changes, and other vision-threatening disorders like glaucoma. If there is a medical diagnosis present, we may be able to bill your medical insurance. There is a **$59.00** fee for baseline photography and optical coherence tomography, if no medical diagnosis is present. _____ I want photography and OCT of my retina done today.

Advance Beneficiary Notice (ABN): AccessorEyes Optometry will inform me of any services or treatments that are not covered by my insurance including Medicare. I authorize my insurance carrier to make payments directly to AccessorEyes Optometry for all medical and optical expense benefits otherwise payable to me for the period of treatment. I understand that I am fully responsible to AccessorEyes Optometry for any and all charges not covered by my insurance benefits as well as any charges that might be incurred for collection or returned checks.

There are two types of health insurance plans that will help pay for your eye care services and optical products. You may have both types and AccessorEyes Optometry accepts most insurance plans in both categories. First, Vision Plans, i.e. VSP, EyeMed, etc. and second, Medical Insurance Plans, i.e. BCBS, Anthem, Aetna, Cigna, etc.

Vision plans only cover routine vision wellness exam, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care, such as the diagnosis, management and treatment of eye health problems and diseases. Therefore, medical insurance must be used for medical eye care.

If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called Coordination of Benefits to do this properly and to minimize your out-of-pocket expenses. If some fees are not paid by your insurance, such as deductibles, co-pays, or non-covered services, we will bill you for these services, as allowed by the insurance contract. Please provide your insurance and/or Medicare cards to our staff member so we can make a copy. We will keep the copy on file for billing your insurance on your behalf.

HIPAA PRIVACY STATEMENT: According to the, "Notice of Privacy Practices" as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required by applicable federal and state law to do the following: maintain the privacy and safeguard the security of your health information; give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information; notify you, along with all other affected individuals, of a breach of unsecured health information; and follow the privacy practices that are described in this Notice while it is in effect. AccessorEyes Optometry is committed to protecting your privacy. This Notice tells about the uses and disclosures we make of your personal health information, including certain rights that you have, and obligations we (AccessorEyes Optometry) are bound to, with respect to such information. Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322.

I have read and accept these policies.

PATIENT OR GUARDIAN'S SIGNATURE______________________________________ DATE______________