PATIENT INTAKE & HEALTH HISTORY

Patient Legal Name:	DOB:	Date:

Your minimum exam copayment today could be: Routine $_____ Medical $_____ Contact Fit $_____(if applicable)
Final charges will be determined once your exam is completed.

Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____

PATIENT INFORMATION

Preferred Name		☐ SMS Opt In*	Gender	Age
Home Phone #	Cell Phone #		Home Address	
***You will receive periodic messages related to your appointment and product pick up. Message frequency varies. Message and data rates may apply. Reply HELP for help, or STOP to stop receiving messages. Terms & Conditions and Privacy Policy at https://aegvision.com/privacy-statement.**				
Email Address			Employer	
SSN (if ins. requires)			Occupation	

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

VISION INSURANCE	MEDICAL INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	City & Zip Code

STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting, and should there be any follow-up appointments required after the three months have past, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ **Date** _____

Patient Name: DOB: Date:

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible.
Please check all of the conditions that apply to you:

Respiratory Issues	☐ Yes	☐ No	**Hematologic Conditions**	☐ Yes	☐ No	**Ear/Nose/Throat Problems**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	**Allergy/Immunology**	☐ Yes	☐ No	**Neurological Disorder**	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No	Multiple Headaches	☐ Yes	☐ No
Endocrine Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Gastrointestinal Issues	☐ Yes	☐ No	**Musculoskeletal Conditions**	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	**Kidney/Bladder Problems**	☐ Yes	☐ No
Cardiovascular Conditions	☐ Yes	☐ No	**Psychiatric Disorder**	☐ Yes	☐ No	**Sexually Transmitted Diseases**	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Depression	☐ Yes	☐ No	**Surgical Operations**	☐ Yes	☐ No

Have you previously had any eye injuries, eye surgeries or eye diseases? ☐ Yes ☐ No If yes, please describe:

Have you experienced any floaters, flashes of light, burning, itching, redness, dryness, double vision, unusual blurry vision, frequent styes/chalazions, or excessive tearing/watering? ☐ Yes ☐ No If yes, please describe:

Do you have light sensitivity or issues with glare while outdoors or driving? ☐ Yes ☐ No ☐ Sometimes
Do you have issues with glare or have eye fatigue while on a computer? ☐ Yes ☐ No ☐ Sometimes

Are you currently being treated for any other medical conditions? ☐ Yes ☐ No If yes, please describe:

Please list any medications you are currently taking *(Including hormones, vitamins, birth control, aspirin, other anti-inflammatory, eye drops, etc.)* : ☐ None

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Are you currently pregnant or nursing? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐ Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

CONTACT LENS INFORMATION

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, please list the brand: _____

How many hours a day do you wear contacts? _____ How often do you throw away your lenses? _____

Do your eyes feel dry while wearing contacts? ☐ Yes ☐ No What do you use to clean your lenses?_____

FAMILY HISTORY

Has anyone in your family had any of the following illnesses?

Blindness*	☐ Yes	☐ No	Relationship: _____
Cancer*	☐ Yes	☐ No	Relationship: _____
Cataract	☐ Yes	☐ No	Relationship: _____
Color Blindness*	☐ Yes	☐ No	Relationship: _____
Diabetes*	☐ Yes	☐ No	Relationship: _____
Glaucoma*	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
High Blood Pressure*	☐ Yes	☐ No	Relationship: _____
Lazy Eye*	☐ Yes	☐ No	Relationship: _____
Macular Degeneration*	☐ Yes	☐ No	Relationship: _____
Respiratory Disease	☐ Yes	☐ No	Relationship: _____
Retinal Detachment*	☐ Yes	☐ No	Relationship: _____

**Additional testing may be covered through your medical insurance.*

For Office Use Only

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Patient Name:_____
Date of Birth: _____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS and NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have the legal authority to authorize the examination and treatment of the above listed patient by AEG Vision managed practices. I understand that the examination and treatment may include the use of various exams or tests (including, but not limited to: comprehensive eye examinations, glaucoma testing, pupil dilation, and contact lens fitting), medications (including dilating or numbing agents and dry eye assessment drops), and other diagnostic procedures and tests normally provided in an optometry practice.

I understand that my medical information provided by me, and collected during evaluation, including recordings (photographs, video, electronic), may be collected, used, and disclosed only as necessary for:

- Treatment, payment, and healthcare operations purposes,
- Public health purposes, health oversight activities, accreditation, and other activities that promote wellness; and
- Other purposes as permitted by law.

If retinal imaging, foreign body removal, punctual occlusion, an amniotic membrane graft, dry eye disease treatment or other procedures are required and not emergent in nature, then this will be explained to me by an Optometrist or Optician. If this occurs, I will be asked to give additional written consent for these procedures.

By agreeing to receive treatment:

- I authorize the examination and treatment of the patient as the legal representative (or self, if the patient).
- I acknowledge:
  - If this is my first visit to the practice that I have received a copy of the AEG Vision Notice of Privacy Practices.
  - I have the right to review the AEG Vision Notice of Privacy Practices before signing this form.
  - As provided in the Notice, the terms of the Notice may change. If we change our Notice, I am aware the Notice of Privacy Practices can be obtained from our website www.aegvision.com, or from the practice location, at any time.
- The Notice of Privacy Practices provides information about how we use and disclose health information about you. I consent to the collection and sharing of information as indicated above and the uses and disclosures detailed in the Notice of Privacy Practices, including releasing my medical information to my insurance company(s) as needed to process my insurance claim(s).
- I understand I have the right to request that AEG Vision and its affiliated practices restrict how protected health information about me is used or disclosed for treatment, payment or health care operations, however, we are not required to agree to this restriction.
- I understand this authorization applies and extends to subsequent visits and appointments at this practice as well as other AEG affiliated practice locations, and that I have the right to revoke this consent, in writing, except where we have made disclosures based upon your previous consent.

I certify that I have read and understand the above statements, I have been provided a copy of the AEG Vision Notice of Privacy Practices if this is my first visit, and that I am providing my consent to treat.

_____	_____	_____	_____AM/PM
Patient/Legal Representative Signature	**Relationship to Patient**	**Date**	**Time**
_____	_____		
Legal Representative Name (Print)	**Name of Patient (Print)**		

HIPAA ACKNOWLEDGEMENT & EMERGENCY CONTACT FORM

Patient Name: _____ Date of Birth: _____

HIPAA is a US law designed to provide privacy standards to protect patient's medical records and other health information provided to health plans, doctors, other health care providers in addition to individuals known to the patient (including family members or caretakers). The AEG Vision Privacy Policy and Notice of Privacy Practices can be found on the company website for full details regarding how AEG and managed practices use, share, disclose, protect, and release your personal information.

I AUTHORIZE AEG VISION AND ITS MANAGED PRACTICES TO RELEASE THE FOLLOWING INFORMATION EITHER DURING OR FOLLOWING MY APPOINTMENT OR IN CASE OF AN EMERGENCY:

☐ Exam Notes ☐ Treatment Plans ☐ Merchandise Purchased ☐ All records
☐ Test Results ☐ Prescriptions

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**

_____

If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

I understand that authorizing the release of this health information is voluntary. I do not need to complete this form in order to proceed with treatment.

Patient Signature: _____ Date: _____

Authorized Representative/Parent: _____ Date: _____
Printed Name of Authorized Representative/Parent: _____
Relationship to Patient: _____
Address and Phone # of Authorized Representative/Parent: _____