OPTOMEYES HEALTH, INC

WELCOME TO OPTOMEYES HEALTH. THANK YOU FOR CHOOSING US FOR YOUR EYE CARE NEEDS. PLEASE TAKE A MOMENT TO COMPLETE THE FOLLOWING FORM.

FIRST NAME:_____ MI LAST NAME_____

ADDRESS CITY STATE/ZIP

SS# Date Of Birth:_____ Phone #_____

EMAIL: _____

EMERGENCY CONTACT/RELATIONSHIP: PHONE:

NAME OF PRIMARY INSURANCE _____ID#_____

VISION INSURANCE ID#

INSURED NAME: _____

INSURED ID # _____ INSURED DOB _____

PATIENT RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____CHILD _____

PLEASE READ:

PLEASE ASSIGN ALL OF MY BENEFITS TO OPTOMEYES HEALTH, INC AND AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT FROM MY INSURANCE COMPANY. I UNDERSTAND THAT ALL BENEFITS QUOTED TO ME ARE NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY AND THAT FINAL DETERMINATION CAN ONLY BE MADE AFTER THE CLAIM PROCESSES. AS SUCH I UNDERSTAND THAT IF SOME FEES ARE NOT PAID BY MY INSURANCE, I AM STILL RESPONSABLE AND WILL BE BILLED FOR THEM. ACCOUNTS 90 DAYS-OLD ARE SUBJECT TO COLLECTIONS, AND THERE WILL BE A SERVICE CHARGE FOR BOUNCED CHECKS. ALL COPAYMENTS, AND NON-COVERED SERVICES, AS PER MY INSURANCE CONTRACT, ARE DUE AT TIME OF SERVICE.

Signature:_____Date:_____

HIPAA Notice of Privacy Policy:
Acknowledge that I have been offered and or received by OPTOMEYES HEALTH, INC:

Signature: _____Date: _____

PLEASE ALLOW THE FOLLOWING INDIVIDUALS ACCESS TO MY RECORDS:

Turn over

SOCIAL HISTORY:
CURRENT OCCUPATION:_____
ALCOHOL USE NONE SOCIAL MODERATE HEAVY
TOBACCO USE: CURRENT SMOKER_____ HOW MUCH:_____
NEVER_____ FORMER: _____ QUIT DATE:_____

SPECTACLE LENS HISTORY:
DO YOU CURRENTLY WEAR GLASSES: YES_____ NO_____
FOR DISTANCE YES_____ NO _____
FOR NEAR YES_____ NO _____
PROGRESSIVE LENS YES _____ NO _____

CONTACT LENS HISTORY:
DO YOU CURRENTLY WEAR CONTACT LENS: YES:_____ NO _____
BRAND:_____

IF NOT A CONTACT LENS' WEARER, ARE YOU INTERESTED IN TRYING CONTACT LENS' AT THIS TIME:
YES: _____ NO _____

REASON FOR VISIT:_____

CIRCLE ALL THAT APPLY TO YOU: ROUTINE EXAM CONTACTS
BLURRED VISION DOUBLE VISION EYE STRAIN
CONCUSSION HEADACHE/MIGRAINE SWELLING/SORE
FLOATERS FLASHING LIGHTS ITCHY EYE DRY EYE
CATARACTS GLAUCOMA POOR NIGHT VISION
AMBLYOPIA (LAZY EYE)

LIST ANY EYE SURGERY:_____

PRIMARY DR'S NAME: _____PHARMACY:_____
GENERAL HEALTH: CIRCLE ALL THAT APPLY:
HIGH BLOOD PRESSURE DIABETES THYROID HIGH CHOLESTEROL
DEPRESSION/ANXIETY HEPATITIS ASTHMA ARTHRITIS SLEEP APNEA
BLEEDING DISORDER HIV/AIDS KIDNEY DISEASE LIVER DISEASE
LUNG DISEASE LUPUS MIGRAINES MULTIPLE SCLEROSIS
HEART ATTACK STROKE ALLERGIES
OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:_____
_____
MEDICATION:_____
_____ALLERGIES:_____
_____

FAMILY HISTORY (MOTHER, FATHER, SIBLINGS, CHILDREN) OF ANY OF THE ABOVE CONDITIONS: PLEASE LIST CONDITION AND RELATIONSHIP:_____

_____