EyeCare About Vegas
Patient History Questionnaire

Date: _____

First Name: _____ MI: _____ Last Name: _____ Nickname: _____

DOB: _____/_____/_____ Sex: ☐ Male ☐ Female Marital Status: _____ SS #_____

Address: _____ Apt: _____ City: _____ State/Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ May we text you? ☐ Yes ☐ No

Work Phone: (____) _____ E-mail: _____

How did you hear about us? ☐ Past patient ☐ Vision insurance ☐ Location (drove/walked by) ☐ Online
☐ Yellow Pages ☐ Friend/Family ☐ Other

Preferred Method of Communication: ☐ E-mail ☐ Telephone ☐ Postal mail

Occupation: _____ Employment Status: ☐ Employed ☐ Unemployed

Employer/School: _____ ☐ Retired ☐ Student

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Native Hawaiian/Pacific Islander
☐ Decline to Answer

Preferred Language: _____

Race:
☐ African-American
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Native American/Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other/Decline to Answer

Primary Vision Insurance:
Insurance: _____
Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____ Date of Birth: ___/___/_____
SSN or Insurance ID: _____
Employer: _____

Secondary Vision Insurance:
Insurance: _____
Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____ Date of Birth: ___/___/_____
SSN or Insurance ID: _____
Employer: _____

Vision History

History of any eye condition(s): _____

Please list all eye drops you use & how often: _____

Last Eye Exam: _____ Optometrist/Eye Doctor: _____

Do you currently wear glasses? ☐None ☐ Distance Only ☐ Computer Only ☐ Reading Only
☐ Bifocal/Trifocal ☐ Progressive (No-line bifocal/trifocal)

Do you wear contacts? ☐Yes ☐No If Yes: ☐ Soft or ☐ Gas Permeable

Contact Lens Brand: _____ How often do you replace your contacts? _____

If you do NOT wear contacts are you interested in a trial fitting: ☐ Yes ☐ No

On average, how many hours per day do you use a computer? _____

Are **you** currently experiencing any of the following?

☐Eyes feel dry	☐Floaters	☐Headaches	☐Eyes itch
☐Eyes strained/tired	☐Flashing lights	☐Double vision	☐Eyes burn
☐Eyes frequently red	☐Halos around lights	☐Blurred vision	☐Eyes water
☐Frequent styes	☐Bothered by light/sun	☐ Other: _____	

Please indicate if any of the following apply to you or a family member (Check all that apply):

Disease/Condition	**Self**	**Family**	**Relationship (blood relatives only)**
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Lazy eye (Amblyopia)	☐	☐	
Eye turn (Strabismus)	☐	☐	
Blindness	☐	☐	
Diabetes	☐	☐	
Heart disease	☐	☐	
Other:			

Medical History

Physician's Name: _____ Last Visit Date: _____ Medication Allergies: _____

List all current medications: _____

Please list all major surgeries and year performed: _____

Check ALL chronic (on-going) problem(s) that apply to you:

General Health:	**Ear/Nose/Throat:**	**Cardiovascular:**	**Respiratory:**	**Genital/Urinary:**
☐Rapid weight loss or gain ☐Fatigue ☐Trauma ☐Pregnant/Nursing	☐Seasonal allergies ☐Hearing impaired ☐Sinusitis	☐High blood pressure ☐High cholesterol ☐Heart attack ☐Vascular disease ☐Stroke	☐Asthma ☐Bronchitis ☐Emphysema ☐COPD	☐Kidney stones/disease ☐Frequent urination ☐STD/STI
Muscle/Skeletal:	**Skin:**	**Neurological:**	**Psychiatric:**	**Endocrine:**
☐Head/neck injury ☐Arthritis ☐Joint pain ☐Ankylosing Spondilitis	☐Eczema ☐Rosacea ☐Psoriasis ☐Skin cancer	☐Alzheimer's ☐Dementia ☐Multiple Sclerosis ☐Migraines ☐Seizures	☐Anxiety ☐Depression ☐Bi-Polar ☐Schizophrenia	☐Thyroid dysfunction ☐Hormone dysfunction
Blood/Lymph:	**Allergic/Immunologic:**	**Gastrointestinal:**	**Other(s):**_____	
☐Anemia ☐Leukemia ☐Bleeding disorder	☐Rheumatoid Arthritis ☐Lupus ☐HIV/AIDS	☐Acid reflux ☐Crohn's ☐Ulcer ☐Irritable Bowel (IBS)	☐ **DENY ALL (Check if this applies)**	

Social:

Tobacco use: ☐ None ☐ Former smoker ☐ Current smoker: _____packs/day ☐ Chewing tobacco

Alcohol consumption: ☐ None ☐ Occasional ☐ _____drinks/day

Non-prescription drug use: _____

Height: _____ Weight: _____

Patient Financial Agreement

Eye Care Services: Our office provides a full scope of eye care services including **routine vision care** (ie: **check** up's, glasses, and contact lenses), as well as **medical eye care** services such as treatment for eye infections, dry eye, and lid disease, treatment and evaluation of ocular allergy, cataracts, glaucoma and trauma related care. Payments for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer has purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier. Depending on the nature of your visit, we may be able to bill your vision plan, insurance, you medical insurance or both. Please present all of your insurance information to the receptionist upon arrival.

Medical Eye Care: **PPO's-** Your medical insurance may be able to be billed for certain eye conditions and procedures that your insurance company deems medically necessary and has included in your policy. You will be given a "Patient History Form" to fill out in advance. Even with this information, it is impossible for our office to determine with any certainty what, if any, charges will be covered by your insurance company. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance. **HMO's**- We do not contract with any HMO's for medical eye care. **If you are an HMO member, you should assume all HMO insurance is NOT accepted by this office** and that payment for services will be due on the day of your visit. If you are an HMO insured patient you may elect to see us and pay for our services directly or see your HMO primary care physician for a referral to an In-Network provider for care instead.

Medicare: Our practice fully participates in the Medicare program. We do not accept assignment of benefits on behalf of each eligible patient. The eye-health examination is a fully covered service under the Medicare program once the yearly deductible of $147.00 has been met. However, as mandated by Federal law, the refraction (determination of eyeglass prescription) is a non-covered service. Each Medicare patient will be charged for the refraction at the time of service during your visit. There is no longer an eyewear benefit under the Medicare program unless the eyewear need immediately follows cataract surgery. The purchase of frames, lenses, lens options and coatings is the responsibility of each Medicare patient.

Cancellation Policy: Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $30.00 service charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

Methods of Payment: We take all major credit cards, debit cards, cash, and checks. Balances due, not withstanding insurance balances, that are not paid in full within **90** days may be turned over to an outside collection agency for final payment. Any collection fees are the responsibility of the patient. We will bill insurance claims for you as a courtesy.

I have read and understand the office financial policies and agree to the conditions above and further agree that I, as the patient receiving services or the responsible party for the patient, am ultimately responsible for payment of any materials ordered and/or services rendered.

Patient Name: _____ Date: _____

Signature: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

EyeCare About Vegas
Christopher Coker, OD
Pierre Nguyen, OD
2055 E. Windmill Lane Ste. 105
Las Vegas, Nevada 89123
Tel: (702) 731-2233

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
Obtain Payment from third party payers for my health care services
Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my health care provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my health care provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

IF DR. CHRISTOPHER COKER OR DR. PIERRE NGUYEN ARE BILLING INSURANCE ON MY BEHALF, I AUTHORIZE THEM TO OBTAIN (FROM MY INSURANCE CARRIER) ANY INFORMATION NEEDED REGARDING BENEFITS AND MAXIMUMS AVAILABLE, SERVICES PROVIDED BY HIM OR ANY OTHER OPTICAL PROVIDER OF CARE THAT WILL HELP HIS OFFICE TO OBTAIN BENEFITS ON MY BEHALF. ALL BENEFITS ARE ASSIGNED TO CHRISTOPHER COKER, OD PLLC (DBA EYECARE ABOUT VEGAS).

Patient Name: _____ Date: _____

Signature: _____

Dependent family members also covered by this authorization and acknowledgement:

For office use only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

□ The patient refused to sign
□ Communication barriers
□ Emergency situation