

New Patient Information Sheet

First Name: _____ Last Name: _____

DOB: _____ Male: Female: SSN: _____

Address: _____

City/State/Zip: _____

Home: _____ Cell: _____ Work: _____

Email Address: _____

Employer: _____ Occupation: _____

Primary Care Doctor: _____ Office Number: _____

Endocrinologist: _____ Office Fax: _____

Are you: Single: Married: Divorced: Widowed:

Do you smoke? Packs per week? _____ Yrs since you quit? _____

Do you drink alcohol? Drinks per week? _____

Do you use a computer? Hours per week? _____

Do you exercise? Times per week? _____

Hobbies? _____

How did you hear about our office? _____

Patient Ocular History

Ocular History	Patient	Family	Relationship to Patient (Parents, Siblings, Children only)
Blurred Distance Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Decreased Night Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry, Itchy or Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Medical History

Medical History	Patient	Family	Medical History	Patient	Family
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

List all current medications and vitamins/supplements/non-Rx medications (if you have a printed list we can make a copy instead of writing them out): _____

List all allergies to medications (Penicillin, Sulfa, etc): _____

List any recent major surgeries: _____

We strive to communicate with you in a fast and effective manner that maintains your right to privacy. These communications may include appointment reminders and confirmations, order status updates, office hours and availability updates, billing information, feedback requests, and the occasional marketing message relating to new technology or services available, etc. Most messages are sent via text or email but occasionally you may receive phone calls if necessary.

I agree to communicate via: All Text Email Phone Call

I certify that all of the information provided is correct to the best of my knowledge. I will notify the office if any of the information above changes. I have read and understood the Notice of Privacy Practices, the Insurance and Billing Information Page, and the Cancellation and No Show Policy for Sugar Land Total Eye Care and that I may request a copy for my records as outlined in the Privacy Practices.

Signature: _____ Date: _____

Insurance and Billing Information

Many of our patients have both vision and medical insurance and we want you to understand the differences between the two. This is important because they differ in what they cover, pay, etc.

Vision Insurance (VSP, Eyemed, Spectera, Superior Vision, Davis Vision, etc) is primarily designed to determine a prescription for glasses or contacts, help pay for materials and to evaluate the basic health of the eye. It is not equipped to deal with complex medical conditions, diagnoses or treatment plans. Most medical testing is not covered by these plans. Therefore, the co-pay for this service is usually lower.

When a medical condition or diagnosis is present (such as high blood pressure, diabetes or an eye disease such as an eye infection, dry eyes, allergies, glaucoma, cataracts, etc), it is necessary to file with your medical insurance (United Health Care, Blue Cross, Medicare, Aetna, Cigna, Humana, etc). Any co-pays or co-insurance you have for medical specialists will then apply. We will also need to check whether you met your deductible or not. There are several levels of medical exam complexity with varying fees. Some components of medical exams may not be covered by your insurance, therefore you would be responsible for those fees. Medical fees are usually higher than vision fees. **If you do not have medical insurance but require a medical exam, please realize that you will pay a higher fee than the normal well-visit exam.**

The Refraction (the process of evaluating your visual system and determining if you need a glasses prescription) is a NON-Covered service by Medicare and some other medical insurance companies and they have deemed it to be the patient's responsibility. We will do our best to verify whether your non-Medicare medical insurance company will cover it or not. We currently charge \$50 for the refraction if you must pay out of pocket for it.

If you have insurance, we HAVE to be able to verify coverage before you are seen. The ONLY exception to this is an ocular emergency.

Our office does not make these rules, they are defined by the insurance companies. Often we will not know which type of exam you require until we start our testing. We try to be a provider on as many insurances as possible and we will file those claims for you when there is a medical problem. In the event that we do not take yours, we will give you a printed itemized receipt to file with your insurance company.

By signing the previous page you state that you understand the above and assign all benefits to us. Whether or not you have insurance, you also understand that you are responsible for your charges, and you agree to pay for any attorney/collection fees of up to 35% of your original billed amount if you fail to pay your bill in a timely manner. Since exam exams are a service, NO refunds are available.

All fees, insurance co-pays and contact lens evaluation fees (that insurance may not cover) are due at the completion of your exam.

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you notify the office at least 24 hours before your scheduled appointment time. This will allow for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made with less than a 24 hour notice, we are unable to offer that slot to others.

Appointments that are cancelled with less than 24 hour notification may be subject to a \$25.00 Cancellation Fee. Patients who do not show up for their appointment without calling to cancel their appointment will be considered as a no show. This too may be subject to a \$25.00 No Show Fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours, in this instance fees may be waived per Dr. Idiculla's approval.

Information about Dilation

The dilated retinal exam allows for a more thorough examination of the inside of the eye. It uses eyedrops to open your pupils as wide as possible to enable a clear view of the retina. It can reveal conditions such as glaucoma, cataracts, retinal disease, ocular tumors, and also other conditions associated with diabetes and high blood pressure. Side effects include sensitivity to light and blurry near vision lasting 3-4 hours. You may drive with caution following dilation. If you do not have sunglasses, a throw away pair will be provided for you.

All new patients and those with history of diabetes, high blood pressure, floaters, flashes of light, or any type of eye disease including above average nearsightedness are especially urged to undergo this procedure along with the iWellness screening tests.

iWellness Screenings

We are pleased to offer iWellness screening images to help determine and document the underlying health of the eye including the retina and optic nerve. These will serve as baseline images in your patient record and can help with diagnosis and management of future changes that may occur in your eyes. **We recommend these images on patients 18 years of age and older annually, especially if there is a family history of any diseases such as Glaucoma, Diabetes, High Blood Pressure, Macular Degeneration, or Cancer.**

If you choose to have the iWellness screening images today, please understand that your medical insurance **will not** be filed for these tests at any time. These tests are not billable to insurance. The iWellness diagnostic machines are used to find early signs of disease processes and insurance companies only pay for the tests after a diagnosis is made.

iWellness Screening Package	\$49
• Optomap screening image- Wide angle view of the retina	
• OCT screening image- Cross sectional view of the macula and surrounding retina	
One individual test listed above	\$39

If you have any questions about these tests please don't hesitate to ask.