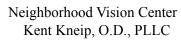


Welcome! Please fill out completely

PATIENT REGISTRATION:				
Name:First Middle Last	Date of Birth:	Age:	Today's Date:	
First Middle Last				
Address:	City:		State: Zip:	
Home Phone: Work Phone:	Cell Phone:		E-Mail:	
Sex: □ Male □ Female How would you prefer	r to be contacted?	□ Work □ Ce	ell 🗆 E-Mail	
Patient's Social Security #:	If student, grade:	School:		
Occupation:	Employer:			
Marital Status: Spouse or E	Emergency contact name:			
Primary Care Physician:		Last M	Iedical Exam:	
f the patient is a child, Parent / Guardian name:		Last eye exam:		
For new patients: How did you hear about us?				
□ Friend / Acquaintance □ Insurance Plan □ Dr	riving by \Box Phone book \Box	Internet Other		
If referred by a friend or family member, who:				
VISION INSURANCE:				
Who is the primary insured person on the vision insu	urance plan?: □ Self (the pat	ient) □ Spouse of t	the patient Parent of the patient	
Insured's name (if other than the patient): Insured's Date of			than the patient):	
Insurance company:	Insured's e			
Insurance company's address:	Insured's S	Insured's Soc. Sec. # (if other than patient):		
Insured's member ID #:	insured s g	10up #		
PRIMARY MEDICAL INSURANCE:				
Who is the primary insured person on the medical ir	nsurance plan?:			
Insured's name (if other than the patient):	Insured's I		than the patient):	
Insurance company:Insurance company's address:	Insured's e	mployer:	han patient):	
Insurance company's address Insured's member ID #:		roup #:		

SECONDARY MEDICAL INSURANCE:

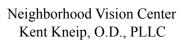
 $\hfill \square$ If there is also a secondary Medical Insurance, please check here and notify the receptionist





PERSONAL EYE HISTORY

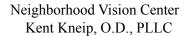
Chief complaint / Reason	n(s) for visit:			
Current problems with y	our eyes (Check all that app	ly):		
 □ Blurred vision □ Flashes □ Dryness □ Itching □ Tearing 	□ Burning	□ Loss of vision or blind spots □ Floaters or spots in my eyes Infection of the eye or lid □ Mucous discharge Foreign body sensation □ Eye pain or soreness Sandy or gritty feeling □ Glare or light sensitivity □ Check here if none of these apply		
Past or present eye h	istory (Check all that a	oply to your eyes):		
 □ Cataracts □ Glaucoma □ Blindness □ Bell's Palsy 	 □ Macular degeneration □ History of eye exercises □ Previous eye infections □ Retinal Detachment 	☐ Styes or chalazions	□ Prominent eyes □ Lazy eye □ Keratoconus □ Check here ij	☐ Dry eyes ☐ Crossed or turned eye ☐ Artificial eye f none of these apply
Please list any eye drops	you are using (include OTC	C drops):		
Have you ever had any e	eye injuries?	No If yes, please explain	:	
Have you ever had any e	ye surgeries? Yes	No If yes, for:		
Do you do a lot of detail	ed near work, or work a lot a	at a computer? □ Yes □	ı No	
Hobbies:	Sports:		Leisure activit	ies:
Do you wear glasses?	□ Yes □ No □ Never	Do you wear contac	ct lenses?	□ No □ Never
FAMILY MEDICAL	AND EYE HISTORY			
This applies to <u>family</u> <u>m</u> B brother S sister):	embers. Please check yes or	no for each condition. If y	res, list who it applies to	o (F father M mother
Family Medical History		Family Eye Hi	•	
Cancer:	□ Yes □ No	Glaucoma	□ Yes	
Diabetes: Heart Disease:	□ Yes □ No	Keratoconus: Macular Degen	☐ Yes peration: ☐ Yes	□ No
High Blood Pressure:	□ Yes □ No	Retinitis Pigme		
How many siblings (brown	thers and sisters)?			





PERSONAL MEDICAL HISTORY

Do you have any allergies to any medica	tions? □ Yes	□ No	If yes, list: _		
Do you smoke/use tobacco currently?	□ Yes □ No	If yes, l	now often?		
Do you drink alcohol?	□ Yes □ No	If yes, l	now often?		
List any major injuries, surgeries and ho	spitalizations vou ha	ive had:			
	-p	_			
Are you pregnant? □ Yes □ No	If pregnant:	Week	s / Months	Are you nursing?	□ Yes □ No
Are you taking any prescription medica	ations?		□ Yes	□ No	
Are you taking any over-the counter me	edications?		□ Yes	□ No	
If yes, please check the medical condition	on and list the medical	ations be	low:		
Disease / Condition	Medications		Disea	ase / Condition	Medications□□
□ Allergies (environmental)		□	Anemia □ B	Bleeding problems	
□ High blood pressure			Lupus		
☐ Heart trouble/problems			Fibromyalgia	ı	
□ Cholesterol problems			Sjogren's		
□ Stroke		_		ema 🗆 Psoriasis	
□ Vascular disease		_	Warts □ Vitil	ligo □ Sarcoid lesions	
□ Recent weight loss □ gain			Rosacea		
□ Fever			Shingles		
□ Fainting □ Dizziness			Arthritis (Ost	teoarthritis)	
□ Diabetes, Type □ 1 □ 2 □ Diet		_	Rheumatoid a		
□ Hypoglycemia			Injury to join	t or spine	
□ Thyroid problems			Muscle pain	•	
□ Graves disease			Headaches (n	migraines)	
□ Pituitary disorder			Headaches (n		
□ Gout			Multiple scle		
□ Hormone imbalance		_	Parkinson's d		
□ Menopause		_	Alzheimer's o	disease	
□ Diarrhea □ Constipation		_	Siezures		
□ Acid reflux			Cerebral pals	У	
□ Ulcer □ Stomach problems			ADD □ ADH	HD	
□ Colitis □ Crohn's			Depression		
☐ Hepatitis ☐ Liver problems			Anxiety		
□ Bladder infections/problems			Insomnia		
□ AIDS □ HIV positive			Other psychia	atric problems	_
☐ Syphilis ☐ Gonorrhea ☐ Herpes			Asthma	and prooreing	
☐ Kidney problems/kidney stones			Bronchitis		
☐ Birth control			Emphysema	□ COPD	
☐ Sinus problems/hay fever			Cystic fibrosi		
☐ Chronic cough			Sleep apnea	- ~	
☐ Hearing loss				toms or Conditions	
□ Ear infection □ Vertigo			June Samp		
□ Cancer, type					





PUPIL DILATION and OPTOMAP IMAGING

As part of a comprehensive eye exam our doctor looks at the retina, which is the tissue that line the inside of the back of the eye. Viewing the retina is necessary to detect and prevent eye diseases that could lead to vision loss or blindness. Many diseases of the eye have no early symptoms and may not be detected without a thorough retinal exam. The view our doctor gets of your retina depends on the size of the **pupil**, which is the opening that regulates the amount of light entering the eye. When light is shined into the eye to evaluate the retina, the pupil normally constricts. This limits the view our doctor gets of your retina. So looking at the retina through an **undilated pupil** is a limited view.

A much more comprehensive view is obtained when the **pupil is dilated**. This is done with medical eye drops. If you choose dilating drops the side effects will include sensitivity to light, blurred near vision and occasionally blurred distance vision, depending on your prescription. These side effects will usually last for about 4 to 8 hours depending on the color of your eye and the strength of the eye drop. The dilated retinal exam is at no extra charge. Neighborhood Vision Center provides complimentary sun protection with a dilated exam.

Another comprehensive view of the retina is obtained with the retinal Optomap. The Optomap is painless and requires no drops and does not affect your vision. This is similar to taking a photograph, but it gives a much broader view of the retina than we get with a traditional camera. It gives us both 2 and 3-dimensional images of your eye. The image of your retina is kept on file for comparison at subsequent visits. The Retinal Optomap is not usually covered by insurance and has a charge of \$ 29.

A dilated exam and/or an Optomap is strongly recommended by our doctors for all patients yearly.

Pupil dilation:	☐ Yes, I want pupil dilation today	□ No, I do not want pupil dilation today
Optomap:	☐ Yes, I want the Optomap retinal exam today	□ No, I do not want the Optomap retinal exam today
Patient / Guar	dian signature	Date



SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Consent to Treatment: I hereby consent to any routine procedures, medical treatment or facility services rendered under the general and specific instructions from the attending Optometrist.

Release of Information: I hereby authorize any person/institution rendering care to furnish all information concerning this claim, as noted in the HIPAA Notice of Privacy Practices. Neighborhood Vision Center may disclose all or any part of my medical record and / or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under direct contract to Neighborhood Vision Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Neighborhood Vision Center may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Financial Acknowledgement: I authorize payment for my vision and medical benefits directly to the Neighborhood Vision Center. I agree that if my employer, insurance carrier or plan sponsor (hereafter referred to as "plan") denies payment of all or any portion of my claim, I will be financially responsible for payment of all outstanding charges, subject to the agreement between the Neighborhood Vision Center and my plan.

Assignment of Benefits: I authorize the use of the signature below for all insurance submissions from the Neighborhood Vision Center and its doctors on my behalf.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Kent Kneip, OD, PLLC, dba Neighborhood Vision Center, for services furnished me by Neighborhood Vision Center. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claims forms, my signature authorizes releasing the information to the insurer or agency shown. Neighborhood Vision Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Professional Fees: Professional fees are due upon completion of examination. Professional fees are non-refundable.

Insufficient Fund Policy: I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payments thereafter, and I will be obligated to pay a returned check fee of \$25.00.

HIPAA Notice of Privacy Practices: I understand that I have been given the opportunity to view the Privacy Policy. I understand that if I desire a copy, one shall be given to me by the office staff. The policy is located on the table in the waiting area of the lobby. I understand that I may contact the HIPAA compliance officer at the Neighborhood Vision Center with any questions.

Beneficiary Signature or Authorized Party	Date		
For staff use only: Reviewed registration info., med. hx, testing auth., & info. above: Tech Init.	Dr. Init	Date	