Personal Medical Eye History

Name _____ **Date**_____

	NO	YES	
		NOW	PAST
Cataracts			
Glaucoma			
Macular Degeneration			
Retina Disease			
Retina Detachment			
Flashes/Floaters (circle which)			
Distorted Vision / Halos (circle which and explain)			
Eyes Feel Dry			
Eyes and Mouth Dry			
Eyes Feel Sandy or Gritty			
Eyes Itch			
Eyes Burn			
Eyes Watery (Tear a Lot)			
Eyes Often Look Red			
Eye Pain or Soreness			
Chronic Eye Infection / Sties			
Amblyopia (also called "lazy eye")			
Eye(s) Cross Inward (Esotropia Strabismus)			
Eye(s) Cross Outward (Exotropia Strabismus)			
Cornea Disease			
Optic Nerve Disease			
Other:			

What is your total daily exposure to all of these digital or electronic devices: Computer, smart phone, tablet, compact fluorescent lights, or reading under an L.E.D. bulb?

2-4 Hours □ , 5-7 Hours □ , 8-10 Hours □

What is your total daily exposure of sunlight exposure **(when not wearing sunglasses)** including all of these tasks: Doing errands, getting in/out of your car, or outdoor tasks like gardening and exercise?

2-4 Hours □ , 5-7 Hours □ , 8-10 Hours □

Medical History

Today's Date: _____/_____/_____

PATIENT INFORMATION

Name: _____ Birth Date: _____/_____/_____ Age:_____ □ Male □ Female

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ SS#:_____

E-Mail Address:_____ Occupation: _____ Single, Married, Other:_____

Emergency Contact Person: _____ Relationship to Patient: _____ Phone: _____

Last eye exam _____/_____/_____ **If new to office, how were you referred?**_____

Do you currently have an open Motor Vehicle Accident or Workers Compensation Case? □ ***Yes*** □ ***No***

PRIMARY MEDICAL INSURANCE INFORMATION ***(All information must be filled out completely in order for Insurance Claim to be submitted.)***

Medical Insurance Company:_____ I .D.#:_____

Primary Insurance Holder:_____ Relationship to Patient:_____

Address of Primary Insurance Holder (if different from patient) _____

Birth Date:_____/_____/_____ S.S.#:_____ Phone Number: _____

SECONDARY MEDICAL INSURANCE INFORMATION

Medical Insurance Company:_____ I .D.#:_____

Secondary Insurance Holder:_____ Relationship to Patient:_____

Address of Secondary Insurance Holder (if different from patient) _____

Birth Date:_____/_____/_____ S.S.#:_____ Phone Number: _____

VISION PLAN INSURANCE INFORMATION

Medical Insurance Company:_____ I .D.#:_____

Vision Plan Insurance Holder:_____ Relationship to Patient:_____

Address of Vision Plan Insurance Holder (if different from patient) _____

Birth Date:_____/_____/_____ S.S.#:_____ Phone Number: _____

MEDICAL HISTORY

- Are you pregnant and / or nursing? □ **Yes** □ **No**
- Do you have allergies to medications or eye drops? □ **Yes** □ **No** **If yes, explain:** _____
- Do you engage in tasks which can cause eye injury? Such as: carpentry, hunting, handyman work, contact sports or other tasks which could cause eye injury, vision loss, or blindness? □ **Yes** □ **No** **If yes, explain:** _____
- List major injuries, and major surgeries (including head injury, eye injury, eye surgery): _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings; living or deceased) for the following conditions

DISEASE / CONDITION	***Yes***	***No***	***?***	***RELATIONSHIP TO YOU***
Cataracts	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other _____	□	□	□	_____

Social History

Do you drive? □ **Yes** □ **No** If yes, do you have visual difficulty when driving? □ **Yes** □ **No** If yes, please describe:

_____

Do you use tobacco products? □ **Yes** □ **No** If yes, type / amount / how many years: _____

Do you drink alcohol? □ **Yes** □ **No** If yes, type / amount / how many years: _____

Have you ever tested positive for: □ Hepatitis C □ HIV □ AIDS □ Syphilis □ None

At this moment, do you currently have a cough, cold, flu, or upper respiratory infection: □ Yes □ No

Your History

Do you currently have, or have you ever had, problems as follows (if "YES" please indicate "NOW" or "PAST"):

	YES	*NOW*	*PAST*	*NO*
CONSTITUTIONAL				
Fever, Weight Loss / Gain	□	□	□	□
Dermatological				
Skin	□	□	□	□
NEUROLOGICAL				
Chronic Headaches	□	□	□	□
Stroke	□	□	□	□
Multiple Sclerosis	□	□	□	□
Head Injury	□	□	□	□
ALLERGIC / IMMUNOLOGIC	□	□	□	□
ENDOCRINE				
Thyroid / Other Glands	□	□	□	□
EARS, NOSE, THROAT				
Chronic Allergies	□	□	□	□
Chronic Sinus Congestion	□	□	□	□
Chronic Post Nasal Drip	□	□	□	□
Chronic Cough	□	□	□	□
Dry Throat / Mouth	□	□	□	□
RESPIRATORY				
Chronic Bronchitis	□	□	□	□
Emphysema	□	□	□	□
BODY IN GENERAL				
History of Serious Physical Trauma	□	□	□	□

	YES	*NOW*	*PAST*	*NO*
VASCULAR / CARDIOVASCULAR				
Elevated Cholesterol / Triglycerides	□	□	□	□
Diabetes	□	□	□	□
Heart Pain	□	□	□	□
High Blood Pressure	□	□	□	□
Vascular Disease	□	□	□	□
GASTROINTESTINAL				
Chronic Diarrhea	□	□	□	□
Chronic Constipation	□	□	□	□
GENITOURINARY				
Genitals / Kidney / Bladder	□	□	□	□
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis	□	□	□	□
Chronic Muscle Pain	□	□	□	□
Chronic Joint Pain	□	□	□	□
LYMPHATIC / HEMATOLOGIC				
Anemia	□	□	□	□
Bleeding Problems	□	□	□	□
PSYCHIATRIC / PSYCHOLOGICAL				
Depression	□	□	□	□
Anxiety	□	□	□	□
Bipolar	□	□	□	□
History of Serious Emotional Trauma	□	□	□	□

MEDICATIONS

If you do not take any medications, please check □ **NONE**

Please list any medications you take, prescribed or over-the counter, including oral contraceptives, aspirin, vitamins, or eye drops:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

HEALTH CHANGES

If you are a previous patient of ours, have there been any changes in your (above) health history, since your last examination here?

NO □ **YES** □ **If "yes", what is the change:**

_____

_____

Visual Symptoms/Signs

(For All Adults and Children)

(However, if your child is too young to answer specific questions, then answer those questions that can be based on your observations.)

NAME: _____ **AGE:** _____ **DATE:**_____

If you DO wear eyeglasses or contact lenses, the questions apply when you are wearing your vision correction.

If you JUST wear reading glasses, the questions about viewing "at distance" apply when you are not wearing the reading glasses., and the questions about viewing "at near" apply when you are wearing the reading glasses.

If you have had a brain injury or stroke, tell us which vision problems are since that occurrence.

Vision When Viewing at Distance

	Always	Often	Sometimes	Rarely	Never
Blurry vision when viewing at distance?					
Double Vision when viewing at distance?					
Immediately after reading, or after using a computer, and when you look up and far away, is your *distance* vision worse for even a moment?					
At the end of the day, does your *distance* vision get blurry?					
When watching a 3D movie, do you get eyestrain, blur, nausea, headaches, dizziness, motion sickness? (Circle Which)					

Vision When Viewing Within Arm's Length as When Reading or on Computer

	Always	Often	Sometimes	Rarely	Never
Blurry vision, or in/out of focus when reading or on computer? (Circle Which)					
At the end of the day, does your reading or computer vision get blurry?					
Headaches *during* or *after* reading (or computer use)? (Circle Which)					
Double vision or words running together when reading or on computer? **(Circle Which)**					
Skip lines, loses place, when reading? Has to use fingers to keep place? (Circle Which)					
Do you ever close, or cover an eye to read better? **(Circle Which)**					
***Eyes tired,* or do you *feel sleepy* when reading or on computer? (Circle which)**					
Eyestrain, discomfort, or pulling feeling when reading? **(Circle Which)**					
Tends to read *very close* or *very far,* from face? (Circle Which)					
Eyes watery after reading or computer use?					
Do you *blink* or *rub* your eyes a lot when reading? (Circle Which)					

Do you have any other visual complaints? No Yes If yes, please explain:

Pediatric Checklist

For All Children to Age 15

NAME: _____ **GRADE:** _____ **DATE:**_____

Visual Motor Integration

	Always	Often	Sometimes	Rarely	Never
Sloppy writing and drawing skills					
Doesn't space letters well and/or has trouble staying on lines (circle which)					
Poor copying skills					

Visual Memory

	lways	ften	ometimes	arely	ever
Poor recall of information which the child or teen had just been reading					
Trouble with spelling and/or with sight vocabulary (circle which)					

Laterality and Directionality

	Always	Often	Sometimes	Rarely	Never
Confuses right and left hands					
Confuses right and left directions					
Reverse letters and/or words ("b" vs. "d" or saw/was)					

Visual Perception

	Always	Often	Sometimes	Rarely	Never
Confuses similar words (like fight vs. fright or sleepy vs. sleeping)					
Cant recognize the same word repeated on a page					
Trouble recognizing familiar words					

Oculo-Motor/Binocular Vision

	Always	Often	Sometimes	Rarely	Never
Reads slowly					
Reads word by word, not in smooth sentences					
Omits words with reading					
Skips lines, loses place, uses finger to keep place when reading (circle which)					
Difficulty concentrating when reading					

If the patient is a child, also answer these questions:

Has Your Child Been Diagnosed With:

□ ADD/ADHD □ Auditory Processing Problems □ Autistic □ Dyslexia
□ Developmentally Delayed □ Intellectually Challenged □ On the Autism Spectrum □ Learning Disability
□ Concussion / Head Injury

Academic Information

Is work: **Above Average / Average / Below Average**

Does your child struggle with reading? **Yes / No / Sometimes**

Is this child achieving to ability? **Yes / No**

If a grade has been repeated, which grade? _____

Has the child had any special tutoring and/or remedial assistance: **No If "Yes", please explain:**

Sequential Eye Disease and Baseline Testing

Our goal is to keep your eyes healthy, by detecting eye disease and ocular disorders at the earliest possible stage.

That is why sequential, and baseline eye disease testing is recommended.

The tests find eye problems which might otherwise remain undetected.

Unfortunately, healthcare changes have created a system by which insurance companies decide the testing to be done, instead of the doctor deciding what is best.

"Vision Plans" only cover basic eye health testing, and "Medical Plans" only cover basic eye health testing, plus those tests that are medically necessary for the eye problem that you came in for.

For your peace of mind, you have the right to a higher standard of eye care, by choosing elective tests which make your examination more complete.

It is your choice to have one, a few, or all of the optional tests. They do not hurt, are appropriate for adults and children, and can be quickly completed today.

The tests are <u>not</u> covered by any insurance.

The fee for each test is $60.

Choose only the number of tests you can comfortably afford.

The tests are explained on the next page.

Circle "Yes' for those tests you choose.

If not sure about a test, circle "Not Sure".

To decline a test, cross it out.

Please initial and date, to indicate you understand.

Initial: _____ Date: _____

Sequential Eye Disease and Baseline Testing

1) Optovue Screening: *(Microscopic imaging beneath the surface of the retina and optic nerve)*

- This advanced technology test, helps detect early signs of optic nerve and retina disease in adults and children. It looks beneath the surface of the retina, allowing us to diagnosis eye diseases before they are visible on the retinal surface.
- It also helps in the diagnosis of multiple sclerosis, Alzheimer's disease, and detects damage to retinal nerve fibers from stroke, brain injury, or optic nerve disease. It is important when there is a family history of macula degeneration, diabetic retinopathy, or glaucoma.
- Optovue screening also determines if eye disease is the cause of blurry vision, when eyesight does not improve to 20/20 with glasses.
- This is a crucial baseline test for adults and children.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

2) Visual Field Screening: *(Hidden blind spot detection)*

- Helps detect glaucoma, neurological conditions like stroke, or brain tumors even when there are no visual complaints.
- Field screening is always indicated when there are vague visual complaints, headaches, balance issues, complaints of double vision, or reading problems.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

3) Eye Muscle Alignment / Focus Flexibility Testing: *(Eye coordination testing)*

- Indicated when vision goes in/out of focus, or blurs when you look far away after reading.
- Losing your place or skipping lines when reading.
- It also determines if headaches, eyestrain, double vision, dizziness, or depth perception issues are due to poor eye coordination.
- School age children should have this test done because it detects subtle eye muscle and/or focusing problems which can lead to reading or learning issues.
- It can help detect subtle signs of undiagnosed stroke, multiple sclerosis, or diabetes.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

4) Retinal and Optic Nerve Photography: *(Digital color imaging of the back wall of the eye)*

- This test helps find macular degeneration, glaucoma, and eye tumors which may not be detected by other tests.
- Diabetics and high blood pressure related eye damage can also be detected.
- This is an excellent non-invasive pediatric test that shows the health of the back of the eye. It is important because children usually don't sit still enough for us to get a good look at the retina.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

5) Topography: *(Corneal surface distortion testing)*

- Topography detects keratoconus, a hidden cornea disease causing slowly progressive vision loss. It also finds irregular astigmatism, causing eye strain and blurry vision not helped by glasses.
- It is a required test for current contact lens patients and for those considering contact lenses.
- Patients who complain of double vision should have this test because doubled images can be caused by corneal distortion. In addition it helps detect subtle signs of dry eyes.
- Children and adults who do not do well on the "which is clearer, lens one or lens two" part of the eye exam, benefit from this test because it diagnoses astigmatism.
- Topography is required if considering Lasik surgery.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

6) Pachymetry: *(Glaucoma probability test)*

- This test detects a risk factor related to the possible future development of glaucoma. It is appropriate for all ages, and when related to glaucoma it is usually done only once in a person's lifetime.
- It should be considered by uncomfortable contact lens patients for detection of cornea edema.
- People who have a family history of cornea disease, need this test.
- It is required if considering Lasik surgery.

YES_____ **NOT SURE**_____ (I will ask the Doctor)

Office Fee Information

Appointment Policy

We would appreciate 24 hours' notice if an appointment has to be canceled. We understand emergencies happen, but if you miss a few appointments there will be a no show fee. The fee is $85 for a missed appointment which was scheduled for less than a ½ hour, and $185 for a missed appointment that had been scheduled for ½ hour or more.

Payment for Professional Services

Payment for all services, eye wear or contact lenses is due at time of service. If you did not bring your HMO referral or vision plan paperwork for the visit you will be billed our usual fees. We cannot backdate an examination to conform to an HMO referral or for vision plan paperwork presented after the office visit.

If you are a current contact lens patient

Contact lens prescription renewal, requires annual cornea eye health testing in addition to the eye exam. The testing may include, as indicated, vision testing and refraction through your contacts, and/or biomicroscopy with fluorescein for detecting cornea surface disease, and/or eyelid eversion for disease under the eye lids, and/or Topography for cornea distortion disease. The fee is $75 (not covered by any insurance). Be sure you have had your contacts on for at least 3 hours prior to the visit, and bring your glasses with you.

If you want to wear contact lenses, or you used to wear contacts, and want to try again):

At the end of the eye examination we will do tests to determine if your eyes are healthy enough to wear contact lenses.

The tests may include, as indicated, biomicroscopy with fluorescein to detect cornea surface disease, eyelid eversion for disease under the eye lids, Topography for cornea distortion disease, and a Schirmer tear test for eye moisture levels. *The fee is $75 (not covered by any insurance), and is separate from contact lens care examination fees.*

If you pass those tests you will then be scheduled for the initial contact lens care appointment. The fee for contact lens care will be quoted to you in advance.

If you have a vision plan that pays toward a basic contact lens fit and follow up, we will apply your plans payment toward our more complete global contact lens care fee.

If you fail the contact lens related eye disease testing (because your eyes are not healthy enough to safely wear contact lenses), the fee for those tests is $75, (which is not covered by any insurance), but the follow up visits for treatment of eye disease detected by those tests will be covered by your medical plan.

Our Eyeglass Guarantee Against Breakage

Private Pay Eyeglasses purchased here (new lenses /and a new frame) are unconditionally guaranteed against one breakage for one year. (*Except specialty discounted glasses)*.

Lenses into Frames Purchased Elsewhere

A $20 service fee is charged when lenses are to be ground into frames you purchased elsewhere. The fee includes pre-alignment of the glasses before they are dispensed to you, the dispensing visit, and subsequent frame alignments for 6-months. *(That fee is included in the price of frames purchased here.)* Vision plan lenses will only be ground into frames purchased here.

Checking Accuracy of Glasses Purchased Elsewhere

Your optician should verify that his lab filled the prescription of your eyeglasses accurately. If you want us to verify how accurately your prescription was filled, there is a per pair charge: Single vision glasses $35, Bifocals $55, Progressives $75.

That verification fee includes one office visit consultation with the doctor. After that each other visit fee is $75. However, should the consultation for an eyeglasses related visual adaptation be medically related, the visit will be charged to your medical insurance, and you are responsible for any co-pay. Sometimes the doctor has to re-write the eyeglass prescription to make it easier for you to adapt to the new eyeglasses. Be sure your optician will remake your eyeglasses at no charge (as is the custom) if your eyeglass Rx needs modification. *(There is no charge for those services when your eyeglasses are purchased here)*.

If your insurance denies payment of claims

You are responsible for charges denied by your insurance.

Collection of Unpaid Fees

If a collection agency or lawsuit is necessary to enforce payment of unpaid fees, you will be charged interest on the unpaid bill, plus all collection fees, plus attorney fees and court costs. The patient acknowledges to remain as payor of last resort. If your check bounces, there is a $35 bounced check charge in addition to the banks fee.

Report Fees

There is no charge for completing a brief one page "check-the-box" form, or for writing a brief note to the referring physician. However, there is a fee for a more complete "check-the-box" form (if longer than one page), and there is a fee for any written report. Report and form fees start at $125 and range upward, depending on the complexity and extent of the requested information. Report fees are not covered by any insurance, and will be quoted to you in advance. Payment for reports or forms are due in advance.

Please sign/date that you have read and understand:

Name _____ **Date** _____

Medical Insurance vs. Vision Plan Insurance

There are two types of insurance that help pay for eye care services:

1. **Vision Plans (such as VSP, EyeMed)**

   Vision plans only cover routine, basic vision and eye health wellness testing, plus eyeglasses or contact lenses.

2. **Medical Insurance (such as Blue Cross/Blue Shield, Medicare)**
   - **Medical insurance must be used for medical eye care (Diabetes, Dry Eyes, Glaucoma, Etc.)**
   - **Refraction (the part of the exam to establish best eyesight, and/or to prescribe glasses) is not covered by medical insurance or Medicare, and will be collected at the time of the eye examination. However, if you have both medical insurance and vision plan insurance, some vision plans allow us to coordinate benefits by billing refraction to the vision plan, to minimize your out-of-pocket expense. The complexity of refraction determines the refraction fee, which ranges from $65 to $85.**
   - **The fee for copays, deductibles or non-covered services will also be collected at the time of the examination.**

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me to obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Errol Rummel, OD** on my behalf for any services and materials furnished. 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 to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim for or electronically submitted claim), my signature authorized release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Notice of Privacy Practices

It is required that you read the government required "Notice of Privacy Practices". A copy is posted at the front desk, or if you prefer a paper copy is available. Signing at the bottom of this page acknowledges you have read the form. In addition, the government requests that you name a designated healthcare contact person.

Please sign/date that you have read and understand both sides of this form:

Name _____ **Date** _____

Your designated healthcare contact person is:

Name _____ **Relationship to patient** _____

Address _____

Refraction Fee Information

"Refraction" is the vision testing that determines if your vision is the best it can be. Refraction fees vary from $65 to $85 depending on the complexity of your vision problem.

Refraction Coverage for Routine Vision Plan Exams

If you have a vision plan (like VSP, EyeMed, or Davis) and you are here for a routine vision plan, refraction is covered.

Refraction Coverage for Medical Eye Exams

If however you have ocular complaints that sound medical, or you have a known medical condition that can cause eye disease (like diabetes, dry eyes, double vision, or red eyes), or if you have a known eye disease (like cataract or glaucoma) your visit today will be a medical eye exam (not a routine vision plan exam). The doctor will tell you if today's eye exam is medical.

If your exam today is medical, and your vision plan is VSP, your refraction fee may be covered. If refraction is not paid by VSP, you will be billed, which you are obligated to pay.

Other vision plans (like EyeMed or Davis) don't pay for refraction during a medical eye exam, but your "secondary" medical insurance may pay for the refraction. If refraction is not paid by your plan, you will be billed, which you are obligated to pay.

Important:

If today's visit is a medical eye exam, and your vision is not 20/20, a refraction is recommended to determine if your reduced eyesight is due to the eye health problem.

Please sign below to indicate that you understand a refraction during a medical eye exam may not be paid by your vision plan, or by your secondary medical insurance, in which case the refraction fee will be billed to you.

Name _____ **Date**_____