Welcome to our office! We want to provide you with the very best in vision care. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records.

PATIENT INFORMATION

Preferred Name: _______________First Name: __________________ Last Name: __________________ Middle Initial: ____

Social Security #: _______________ Gender: **M** / **F** Date of Birth: ____/_____/_____ Marital Status: **Single** **Married** **Other**

Mailing Address: ___________________________________ City: _______________ State: _________ Zip: _______________

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** ______________________________

Alternate number: ____________________ E-mail address: ____

Whom may we thank for referring you to us? ____

EYE HEALTH HISTORY

How can we help you today? Please circle to indicate if you currently have any of the following symptoms, please indicate which eye:

Annual Examination	Eye Infection	Eye Injury	Twitching Eyelid
Light Sensitive	Discharge from Eyes	Burning Eyes	Watering Eyes
Red Eyes	Dry Eyes	Blurred Vision- Near	Sandy/Gritty Eyes
Itchy eyes	Temporary Loss of Vision	Blurred Vision- Far	Headaches or Migraines
Seeing Halos	Fluctuating Vision	Seeing Flashes	Floaters, Spots
Double Vision	Crossed Eyes	Color Vision, Poor	Eye Strain
Eye Turn	Glaucoma	Cataracts	Other________________________

CURRENT VISION

Date of last eye exam: ______________________________ **Doctor:** _________________________________

Are you interested in wearing contact lenses? **Yes** **No**

How many hours per day do you work on a computer? ______

Have you had LASIK? **Yes** **No**

Are you interested in LASIK? **Yes** **No**

Do you currently wear glasses? If so, how old: _____________

Are you interested in getting new glasses today? **Yes** **No**

<u>CONTACT LENSES:</u> Do you currently wear contacts? **Yes** **No** ***If yes, answer the questions below; if no, continue to next page.***

How often do you replace your contact lenses? ☐ **Daily** ☐ **Weekly** ☐ **2 weeks** ☐ **Monthly** ☐ **3 months** ☐ **6 months** ☐ Annually

What solution do you use to care for contact lenses? ☐ **Biotrue** ☐ **Opti-free** ☐ **Clear Care** ☐ **Boston** ☐ **Other:** _________________

Do you use any contact lens rewetting drops or artificial tears to improve the comfort of your lenses? **Yes** **No**

If yes, which rewetting drops or artificial tears do you use? ___________________________________

Describe any problems or frustrations with your contact lenses*:* ____

Please continue to next page

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with the following conditions? If so, please check the appropriate box:

CONDITION	MOTHER	FATHER	SIBLING	GRANDMOTHER	GRANDFATHER
Diabetes					
High Blood Pressure					
Glaucoma					
Macular Degeneration					

REVIEW OF SYSTEMS

Ocular/Eye Problems	**YES**	**NO**
Inflammatory disorder	☐	☐
Surgery	☐	☐
Glaucoma	☐	☐
Amblyopia (lazy eye)	☐	☐
Cataract	☐	☐
Retinal problems	☐	☐
Macular degeneration	☐	☐
Strabismus (eye turn)	☐	☐
Patching	☐	☐
Constitutional Problems		
Cancer	☐	☐
Fatigue	☐	☐
Developmental disability	☐	☐
Ears, Nose, Mouth, Throat Problems		
Laryngitis	☐	☐
Dry mouth	☐	☐
Hearing loss	☐	☐
Sinusitis	☐	☐
Neurological Problems		
Cerebral palsy	☐	☐
Multiple sclerosis	☐	☐
Tumor	☐	☐
Epilepsy	☐	☐
Psychiatric Problems		
Depression	☐	☐
Insomnia	☐	☐
Cardiovascular Problems		
Vascular disease	☐	☐
Stroke	☐	☐
Congestive heart failure	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐

Respiratory Problems	**YES**	**NO**
Emphysema	☐	☐
Bronchitis	☐	☐
Smoker	☐	☐
COPD	☐	☐
Asthma	☐	☐
Gastrointestinal Problems		
Colitis	☐	☐
Crohn's disease	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Genitourinary Problems		
Prostate Disease/Cancer	☐	☐
STD	☐	☐
Kidney Disease	☐	☐
Musculoskelatal Problems		
Ankylosis Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoarthritis	☐	☐
Skin Problems		
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Endocrine Problems		
Diabetes Insulin-Dependent	☐	☐
Diabetes Non-Insulin	☐	☐
Hormonal Dysfunction	☐	☐
Thyroid Dysfunction	☐	☐
Blood/Lymph Problems		
Large volume blood loss	☐	☐
Anemia	☐	☐
Allergy/Immunologic Problems		
Environmental allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐

Are you pregnant or nursing?
Y N

What is your occupation?
____

List your sports / hobbies:
____
____

If you smoke, how much per day?
____

Do you consume alcohol ?
Y N
If **yes,** how much?
____

Primary Care Physician:
____

Please list any medications you are currently taking:
____
____
____
____

List any medicine allergies:
____
____

List any other allergies:
____

Other condition not listed______________________________

HIPPA/PRIVACY POLICY

I acknowledge that I have the right to review Premier Family Eye Care's Privacy Policy prior to signing this Consent. I authorize the release of medical information to my primary care or referring physician as necessary to process my insurance claims, prescriptions, etc.

Please list below, any person to whom your protected health information can be disclosed.

Name of Person records to be released: ______________________ Relationship: _______________

ROUTINE COMPREHENSIVE VISION EXAMS vs. MEDICAL EYE EXAMS

There is sometimes no way to know prior to the examination which type of exam will be most appropriate. If there are no medical complaints or problems, the exam will be considered a Routine Comprehensive Vision Exam. If you have a medical complaint and/or problem, the exam is a Medical Eye Exam.

Routine Comprehensive Vision Exams:
This exam provides a detailed screening of the eyes and visual system as well as a **Refraction,** which is the service to determine the proper eyeglasses prescription. These exams are intended for healthy patients with no known medical eye issues. Vision insurance can be applied towards Routine Comprehensive Vision Exams. Contact lenses can also be fitted during this type of exam.
(Common vision insurance plans include VSP, Eyemed, Community Eye Care, Superior Vision, etc.)

Medical Eye Exams:
This exam focuses on a specific medical condition. Medical conditions may include eye allergies, dry eye, infection, glaucoma, cataracts, headaches, diabetes, injuries, and more. Medical insurance can be applied to Medical Eye Exams. **No Refraction** is performed during a Medical Eye Exam. If a patient wishes to update their eyeglasses prescription during a Medical Eye Exam they may, however Vision insurance cannot be applied and this service would be the patient's responsibility ($30.00 service fee). Medical insurance cannot be applied to any "routine" vision service.

I understand the difference between Routine Comprehensive Vision Exams and Medical Eye Exams. I also understand the difference between what Vision insurance and Medical insurance may cover and I authorize PFEC to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Print Patient Name____

Signature: ____ Date: _____________________

FINANCIAL POLICY FOR ALL PATIENTS

We make every effort to be on as many insurance panels as we can, both medical and vision, for your convenience. If we are on your insurance company's panel we will file those claims for you as a courtesy. However, the benefits quoted are not a guarantee of final payment required; the final determination can only be made after the claim is processed. In the event that we are out of network with your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim with your insurance for reimbursement.

Applicable co-payments, deductibles and/or coinsurance will be collected at the time of service. You are responsible for all charges not paid for by your insurance.

I agree to make prompt payment in full to PFEC when billed for any and all charges not covered or paid for by my insurance. I also authorize insurance benefits to be to paid directly to PFEC. This authorization is valid until revoked in writing.

Signature: ______________________________________ Date: __________________

PERMISSION TO TREAT A MINOR – Only for patient age 18 or younger

A parent or guardian must be present with a patient under the age of 18 or grant permission for PFEC to see the minor without their presence for examinations. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Signature: ______________________________________ Date: __________________

Relationship to Patient: ______________________________

MEDICARE PATIENTS ONLY

Medicare DOES NOT cover the cost of the Refraction (the part of the eye exam where the prescription for glasses or contacts is determined). Therefore, the patient is responsible for the Refraction Fee in addition to any unmet deductible from Medicare or required copay. The Refraction Fee is $30 and is to be paid on the day of service.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of Medicare insurance benefits either to myself or to the party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: ______________________________________ Date: __________________

Contact Lens Evaluation and Explanation of Fitting Fees

Please understand that contact lens services are NOT included in your annual comprehensive eye exam. Your eye exam includes a prescription for eyeglasses, eye muscle tests, glaucoma tests, dilation and full ocular health assessment.

By law, contact lenses must be evaluated annually and properly fit in order for your eye health and vision to be properly maintained. Most insurance companies DO NOT cover this portion. Following the contact lens evaluation or fitting process you will have a current prescription that will expire in 1 year.

Evaluation: No change in brand or power necessary

Annual Evaluation $45 Applies to existing contact lens wearers who, at the end of the exam, the doctor determines that a change in brand and power is **not** necessary. New patients to our office must bring prescription or boxes with them at time of service to qualify.

Contact Lens New fit: Change in brand or power

There are four levels of fittings depending on the complexity of your prescription and lens type required.

Fitting fees include a complimentary pair of contact lenses, lens case, solution, and any follow up visits within 90 days of the ***initial*** contact lens fitting with our doctor.

Level 1 $60 Basic Soft Contact Lens Fit

Level 2 $90 Advanced Soft or Basic Gas Permeable Contact Lens Fit

Level 3 $160 Soft Multifocal/ Monovision or Advanced Gas Permeable Lens Fit

Level 4 $215 Specialty Lens Fit (i.e. Keratoconus Gas Permeable Lenses; not including scleral lenses)

There is a **$25** charge required for the Contact Lens Insertion and Removal training session by one of our skilled staff

I understand that the fitting fee does not include the cost of the lenses, and that the lens supplies are ordered separately. Contact lens prescriptions may be released after the initial fitting period is successfully completed and all fees are paid.

I understand even with proper care there are risks to wearing contact lenses, and that those risks increase with improper use. I must follow the instructions given to me by the eye care team about the recommended wear and replacement schedule to ensure the health of my eyes. I agree to remove my lenses at the first sign of problems and call the office immediately if I develop unusual pain or redness.

____________________________________ ______________________________

Patient or Guardian Signature Date

DIABETIC EYE EXAMS

The doctors at Premier Family Eye Care perform dilated diabetic eye examinations for all patients that have a diagnosis of diabetes (Type I, Type II, or Current Gestational) whether they are being treated by diet and exercise or medication (oral or insulin). Diabetic eye disease is the number one cause of blindness for adults in the United States and patients with diabetes require special care.

The diabetic eye examination is more involved than a routine comprehensive vision exam. Diabetic patients will have their eyes dilated, be educated about diabetes and its potential effects on their eyes, and thoroughly examined and questioned for diabetes-specific eye problems. It is important that our doctors take this extra time during the exam, because diabetic eye disease can lead to irreversible vision loss. In addition, a report containing the exam findings will be sent to their primary care doctor and/or endocrinologist. Due to the medical nature of the diabetes diagnosis, diabetic eye exams are billed to a patient's Medical insurance carrier, NOT their Vision insurance carrier.

No Refraction is provided during the diabetic eye examination. If a patient wishes to update their eyeglasses prescription during a diabetic eye examination they may, however Vision insurance will not be applied and this service would be the patient's responsibility ($30.00 service fee). If patients have Vision insurance that covers the refraction fee, they have the option to schedule a vision exam on a different day to update their glasses and best utilize their Vision insurance plan benefits.

I acknowledge my understanding and consent to a diabetic eye exam. I recognize that my Medical insurance will be billed for the examination, not my Vision insurance.

____ ____________________

Patient or Guardian Signature Date

For communication purposes, please list any doctors (primary care, endocrinologist, etc) below that you see to manage your health regarding diabetes.

Name of Doctor and/or Practice	Phone #	Fax # (if known)