Welcome to James Tracey Eye Care

Date:_____

Last name:_____ First name:_____ MI:_____

Address:_____

City/State/ZIP:_____

Cell phone:_____ Email:_____

Home phone:_____ Social Security:_____ Date of Birth:_____

Work Phone:_____ Occupation:_____ Employer:_____

Primary Pharmacy: _____ Pharmacy Phone: _____

Do you have vision insurance (Circle one) YES/NO Vision plan ID:_____
If yes, circle one: VSP Eyemed Davis VBA NVA Spectera
Vision plan is in my name: YES/NO If no, who is the vision plan holder:_____

Primary Medical Insurance:_____ Member Name:_____
Member ID:_____ Member DOB:_____ Relationship:_____

Whom may we thank for referring you?_____

**We use text and e-mail for appointment confirmations and office communications. WE NEVER SHARE YOUR INFORMATION. Please let us know if you do not want to receive text messages.

NOTE: In compliance with the HIPAA Patient Privacy Rules, all patient information is kept strictly confidential. Your information is NEVER shared.

In addition to your regular eye examination, there is a contact lens fitting fee associated with contact lenses. Vision plans only cover yearly eye wellness exams, along with contributing to your spectacle or contact lens purchase. Vision plans *do not* cover medical eye care (diagnosis, management or treatment of eye health issues). Medical insurance must be used for medical eye care. For more information you can ask our receptionist or you can visit our website.

I understand that I am responsible for any co-payments that are linked to my examination and/or glasses/contact lens benefit through my vision insurance.

I also understand that medical testing may be necessary and will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular disease such as glaucoma, cataracts, etc.) I understand that I am responsible for any co-pays, co-insurance and/or yearly deductibles that are linked to my medical insurance

If I do not have separate vision insurance and my major medical does not cover the refraction for my glasses, I understand that I am responsible for payment for the refraction and will be billed accordingly.

I authorize payment of benefits to be made directly to Dr. James Sinoway, Dr. Tracy Sinoway, Dr. Evan Tirado and Dr. Negar Sedaghat-Ardakani. I understand and agree that, regardless of my insurance status, (e.g. deductible not met, referral not provided, etc.) I am ultimately responsible for the balance of my account for any services rendered.

Prescription eyewear is customized to each patient, therefore only store credit will be issued for returns or exchanges. Thank you.

All insurance information is the responsibility of the patient and must be given *PRIOR* to exam date or an itemized receipt will be provided for the patient to submit. We cannot back bill your claims. --Thank you.

I acknowledge that I have read & understand the Notice of Privacy Practices of Dr. James Sinoway, Dr. Tracy Sinoway, Dr. Evan Tirado and Dr. Negar Sedaghat-Ardakani's Notice of Privacy Practices.

Signature:_____ Date:_____ Like us on Facebook!

PATIENT HISTORY

Chief reason(s) for visit_____

Please check all that apply:

Are you currently experiencing any of the following:

☐ Blurred vision-distance	☐ Itching	☐ Headaches	☐ Dryness	☐ Pain
☐ Blurred vision-near	☐ Tearing	☐ Flashing lights	☐ Light sensitive	☐ Glare
☐ Fluctuating vision	☐ Burning	☐ Floating Spots	☐ Temporary loss of vision	☐ Discharge
☐ Double Vision	☐ Redness	☐ Eye Strain	☐ Eye Injury	☐ Drooping Eyelid

Other: _____

Have you ever been diagnosed with any of the following EYE CONDITIONS:

☐**None** ☐Glaucoma ☐ Cataract ☐ Macular Degeneration ☐ Retina condition ☐ Keratoconus

Other: _____

Have you ever had any EYE SURGERY for the following:

☐**None** ☐ Eye turn/Muscle ☐ Retina ☐ Cataract ☐ Glaucoma ☐ Cornea

☐ Vision Correction ☐ **Are you interested in Laser Vision correction?**

Comments: _____

Contact Lens History:

☐ **None** Are you interested in wearing contacts? ☐Yes ☐ No

Difficulty with CL Wear: ☐ Yes ☐ No

1. Rate how your contact lenses feel **immediately after** you first put them in.

1 2 3 4 5 6 7 8 9 10

Poor ☐☐☐☐☐☐☐☐☐☐ Excellent

Indicate the time you put your contact lenses in _____

2. Rate how your contact lenses feel **just before** you take them out.

1 2 3 4 5 6 7 8 9 10

Poor ☐☐☐☐☐☐☐☐☐☐ Excellent

Indicate the time you take your lenses out _____

3. Do you use contact lens rewetting drops? Yes / No

If so, how often?_____

What brand of contact lenses do you wear?_____

Comments: _____

Eyeglass History:

☐ **None** ☐ Reading ☐ Distance ☐ Progressive ☐ Bifocals

Are there times when you would prefer not to wear glasses?

Medical Information:

☐ **None** Medications/Drops Used: _____

☐ **None** Allergies: _____

General Health Conditions:

☐**None**	☐ Diabetes	☐ Migraine	☐ Cholesterol	☐ Shingles	☐ Thyroid
☐ Lung Condition	☐ High Blood Pressure	☐ Cancer	☐ Arthritis	☐ Heart Disease	

Are you pregnant or nursing? _____

Other: _____

FAMILY HISTORY:

☐**None** ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Retinal Detachment

☐ Turned Eye ☐ Lazy Eye ☐ Poor Color Vision

Other: _____

SOCIAL HISTORY:

Do you use any of the following? ☐Tobacco ☐ Alcohol ☐ N/A