Welcome to Our Office

Please fill in the following information to help us provide you with optimum care

Today's Date_____ Date of Birth_____ Age_____ M / F SS#_____

Patient Last Name_____ Patient First Name_____MI_____

If Minor, Parent(s) First & Last Name_____ SS#_____

Address_____ City_____ State _____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Occupation_____ Email Address_____

Emergency Contact: Name _____ Relationship_____ Phone_____

How did you hear about our office? Friend/Family member (name) _____

☐ Yellow Pages ☐ Internet Site/Social Media ☐ Insurance Plan ☐ Other Referral_____

Patient Medical and Eye History

What health concerns or problems do you have regarding your eyes today? (circle all that apply)

Dryness	Pain	Redness	Itch	Lid Droop	Watery
Glare	Blur	Strain	Irritation	Haze	Light Sensitivity
Other_____				Family History of Eye Disease	

Date of last eye exam_____ By whom?_____

Do you currently wear contact lenses? ☐No ☐Yes Type_____

Have you ever been diagnosed with or treated for the following eye problems? (circle all that apply)

Cataracts	Corneal Abrasion	Dry eye	Injury	Iritis/Uveitis	Macular Degeneration
Lazy Eye	Retinal Detachment	Infection	Allergies	Glaucoma	Diabetic Eye Disease

Other Eye Disorders (list)_____

Eye Surgeries_____

Current Medications (RX or over the counter) ☐ I provided a separate medication list

If not providing a separate list, list **all** medications including eye drops, vitamins & contraceptives below

_____

_____

Allergies to medication (please list)_____

Are you a smoker? ☐No ☐Yes _____pk/day Drink Alcohol? ☐No ☐Yes _____drinks/day

Have you ever been diagnosed with or treated for the following? (circle all that apply)

Allergies	Anemia	Arthritis	Asthma	High Cholesterol	Developmental Disabilities
Heart Disease	Fibromyalgia	Colitis	Depression	Diabetes	Panic/Anxiety Disorder
Thyroid	Epilepsy	Lupus	Weight Loss	High Blood Pressure	Muscular Dystrophy
Multiple Sclerosis	Cancer (type)_____			Are you currently pregnant or nursing?_____	

Other_____

Name of family physician/practitioner_____Date of last visit_____

Family Medical and Eye Health History

Please circle all the following medical health conditions that have occurred in your family?

Cataracts	Corneal Problems	Diabetes	Macular Degeneration
Heart Disease	High Blood Pressure	Glaucoma	Retinal Detachment/Disease
Other_____			☐Unknown

Accent on Vision Santa Fe

Financial Policy / Insurance Information

We ask that all patients read and sign our financial policy prior to seeing the doctor.

1. Payments and all co-payments are due at the time of service. Please indicate your preferred method of payment today:
   ☐Check/Cash ☐MasterCard/Visa ☐American Express ☐Discover Card ☐Care Credit
2. You will be responsible for all charges that are not covered by your insurance due to co-payments or deductibles.
3. There are no refunds for examinations, treatment, services or material purchases.
4. There will be a $30.00 fee for all returned checks.
5. There will be a $30.00 fee for accounts turned over to our collection agency and additional interest fees may also apply to accounts older than 60 days.

About Your Vision and Medical Insurance

There are two types of third party payors that will help pay for your eye care services and products. You may have both and our practice accepts both. The choice of which to bill is driven by your medical and eye history and/or your symptoms or issues brought up during the exam**. Please initial your understanding _____**

1. Vision care plans (such as VSP, Davis, Spectera, Avesis, etc.)
   - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses.
   - They do not cover diagnosis, monitoring, management or treatment of eye diseases or visits resulting in prescription medications.
2. Medical insurance (such as Blue Cross Blue Shield, Presbyterian, United Health Care and Medicare)
   - Medical insurance must be used if you have any eye health problems or systemic health issues that are associated with ocular complications (such as diabetes, use of high risk medications and prior eye surgeries).
   - If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other or separate the services on different days. VSP does allow coordination of benefits to minimize your out-of-pocket expense.
   - We will bill you for any unpaid deductibles, co-payments or non-covered services as allowed by the insurance contract

Assignment and Release: I hereby authorize third party or insurance payments to be made directly to Accent on Vision and fully understand that I am the responsible party for all fees incurred by me at the above mentioned facility. I also authorize the release of any information required for the processing of those claims.

I, the undersigned, have read and agree to the above policies.

Signature_____ Date_____
Patient (Parent or Guardian if minor)

Medical Insurance:_____ Vision Insurance:_____

Name of Insured:_____ Date of Birth of Insured:_____