DR. JEFFREY ZIGULIS
DR. MADISON SMITH
OPTOMETRISTS

ADVANCED EYE CARE • 1073 PRAY BLVD • WATERVILLE, OH

Welcome To Our Office

Name_____ Today's Date_____
DOB _____ / _____ / _____ Date of Last Eye Exam_____
Address_____ Parent or Guardian_____
City_____ State____ Zip_____ Employer_____
Home Phone_____ Occupation_____
Cell Phone_____ Hobbies_____
Social Security Number_____ - ____ - _____ *Email_____

**for using our patient portal services*

Insurance Information (must be completed to file any claims)

Name of Policy Holder _____
Policy Holder DOB_____ / _____ / _____
Medical Ins_____
Vision Ins_____
Insurance ID#_____
Insurance Group#_____
Patient Relationship to Insured_____
Patient Current Marital Status_____

Please indicate your ethnicity:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic/ Latino
- ☐ Native American
- ☐ I prefer not to answer
- ☐ Other

EMERGENCY CONTACT:

Name_____
Relation_____
Phone_____

Your Release of Health Care Information

I hereby authorize Advanced Eye Care (doctor and staff) to release, disclose, and discuss my medical information to the following persons:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

☐ Please check here if you ***DO NOT WANT*** your health care information discussed with anyone other than yourself.

Optomap Retinal Photos: Ultra-wide Digital Retinal Exam

The Optomap Digital Retinal Exam is a fast, easy and comfortable procedure. It provides a permanent record to track and compare potential eye diseases. It also gives an in-depth view of nearly the entire retina to be used as an educational tool for your doctor to determine the health and wellness of your eye. Please note, this digital retinal exam may include dialation. In most cases, patients do not need to be dilated for this exam, but it still may occur.

If you wish to decline this procedure: By signing below, I understand that a widefield view of the retina is an important part of a comprehensive eye exam and I am declining the Doctor's recommendation to obtain a comprehensive veiw of my retina. I understand that since I am declining, I may have to be dilated in order for the doctor to obtain a complete view of my retina.

Signature or Authorized Party: Date:

Consent & Authorization to Release Information

I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor, medical professional, or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at Advanced Eye Care, the offices of Zigulis Eye Care, Inc.

Signature or Authorized Party: Date:

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Medical / Social History

Name_____ Height_____
DOB_____ / _____ / _____ Weight_____
Last Blood Pressure Reading (Or Average) _____/_____ Sex: ☐Male ☐Female

Personal Medical History
Please indicate if you have any of the following:

Allergy to Meds	Y/N	Eye Disorders	Y/N
Arthritis	Y/N	Fibromyalgia	Y/N
Asthma	Y/N	Heart Disease	Y/N
Cancer	Y/N	High Blood Pressure	Y/N
Depression	Y/N	Migraines	Y/N
Digestive Disorder	Y/N	Neurological Disorder	Y/N
Diabetes	Y/N	Skin Disorder	Y/N

Current Medications
Please list any Rx or over the counter meds:

Name of Medication Reason for Taking

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Oral Contraceptive Y/N Eye Drops Y/N

Name of family doctor:_____
List all meds you are allergic to:_____

Family Medical History
Please indicate if any of your family members have had the following:

Diabetes	Y/N	Blindness	Y/N	High Blood Pressure	Y/N	Retinal Detachment	Y/N
Glaucoma	Y/N	Cataracts	Y/N	Macular Degeneration	Y/N		

Who in your family has these diagnoses?_____

Do you drink alcohol?	Y/N	If yes, type/amount/how long	_____
Do you use illegal drugs?	Y/N	If yes, type/amount/how long	_____
Do you currently use tobacco products?	Y/N	If yes, type/amount/how long	_____
Previously used tobacco products?	Y/N	If female, are you currently pregnant?	Y/N

Ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐Other

Please list any past <u>EYE RELATED</u> surgeries:

Type of Surgery Surgeon's Name Date/Year

_____
_____
_____

How Did You Hear About Our Office?

Friend or Relative - Who?_____
A Healthcare Professional - Who?_____
Insurance List?_____

1. Copays are due at the time of services. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of any medical information necessary to process my claim. I agree to pay for services and/or supplies that are denied by my insurance company. **I understand that if there is a medical diagnosis, my medical insurance, not my vision insurance, will be billed.** This includes, but is not limited to: diabetes, cataracts, glaucoma, dry eye, or any other medical disgnosis. I understand that I will be responsible for any deductible or copays that remain after insurance claims have been reviewed or processed.

2. Release of Information: All records concerning the patient's treatment remain the property of Advanced Eye Care, thought the patient may obtain a copy by making a written request. As a condition of the patient receiving care at Advanced Eye Care, the undersigned consents to the use and disclosure of health information about the patient, including; other health care providers (i) in order to carry out that care and treatment of the patient, (ii) to the extent necessary to determine liability for payment and to obtain reimbursements/ authorization, and (iii) for Advanced Eye Care internal health care operations such as quality improvement, risk management, credentialing, peer review business management, etc.

3. Medicare/Insurance Benefits: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request the payment of authorized Medicare benefits. I authorize a holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, its intermediaries, or carriers of any information needed for this or a related Medicare claim. I understand that Medicare will pay only for services which they determine to be reasonable and necessary under Section 1862(a)(1) of the Medicare Law. If Medicare denies payment for some or all of these services, I agree to pay for them.

Signature or Authorized Party: Date: