Welcome to EyeCare Plus

For faster service, please complete before your appointment

Patient's Name: **Nickname:**

Date of Birth: ☐ **M** ☐ **F** **SSN:**

Street Address:

City: **State:** **Zip:**

Phone#: Home: **Cell:** **Work:**

E-mail:

Employer: **Occupation:**

Emergency Contact Name, Relationship & Phone#:

Communication Preferences

Do you give EyeCare Plus staff permission to send glasses or contact lens prescriptions via the E-mail provided above? ☐Yes ☐ No

Do you give EyeCare Plus staff permission to discuss medical information with the following individuals:
☐ Yes, please list individuals below ☐ No; I do NOT want my medical information shared with anyone else

Name: _____ Phone: _____

Name: _____ Phone: _____

Do you give EyeCare Plus permission to leave a detailed voice-message regarding your healthcare?
☐ Yes, please provide appropriate phone number below ☐ No, please request to return call

Phone: _____

Signature: _____ Date: _____

Insurance Information

Vision Insurance Carrier: Insurance ID#: Primary Insured's last 4 SSN:

Primary Insured's Name: Primary Insured's DOB:

Health Insurance Carrier: Insurance ID#:

Primary Insured's Name: Primary Insured's DOB:

Secondary Health Insurance Carrier (if applicable): Insurance ID#:

Primary Insured's Name: Primary Insured's DOB:

Date:

Health History Information

Patient's Name: **Date of Birth:**

Primary Care Physician:

Office: Address:

Endocrinologist or Rheumatologist (if applicable):

Office: Address:

Pharmacy: Pharmacy Address:

	Yes	No
Do you wear glasses?	☐	☐
Do you wear contact lenses? If yes, what brand & how often do you replace the lenses?	☐	☐
Are you interested in contact lenses?	☐	☐
Are you interested in Lasik Surgery?	☐	☐
Are you Diabetic?	☐	☐
If Diabetic, do you have a history of Diabetic Retinopathy or Macula Edema?	☐	☐
Do you Smoke or use Tobacco products?	☐	☐
Do you drink alcohol?	☐	☐
FEMALES: Are you pregnant or nursing?	☐	☐
Current or Previous Eye Conditions & Injuries: Details:	☐	☐
Eye Surgeries (date & surgeon): Details:	☐	☐
Medication Allergies: List:	☐	☐
Major surgeries: Details:	☐	☐

Family Ocular History		
	Yes	**No**
Glaucoma	☐	☐
Macula Degeneration	☐	☐
Retina Detachment	☐	☐
Ocular Melanoma	☐	☐
Other:	☐	☐

Please list the following:

Current Health Conditions:

☐ None

Current Medications **(Rx, Eye drops & OTC):**

☐ None ☐See attached list

Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. A copy of the full-length notice may be obtained at the front desk or our website. This notice describes how medical information about you may be used and disclosed and how you may access this information. You have certain rights regarding the information we maintain about you. All requests must be made in writing. These rights include: the right to inspect and copy medical records (fees apply, federal regulations allow 30 days for completion); the right to amend; the right to a paper copy of this notice; the right to request restrictions; the right to request confidential communication. Examples of how we use and disclose your information include: medical treatment, emergency situations, worker's compensation programs, to obtain payment for our services from your insurance, appointment reminders, research and to run our practice more efficiently.

Assignment of Benefits

I request that payment of authorized insurance benefits (Medicare, commercial or vision insurance) be made to EyeCare Plus for any services rendered to me. I authorize release of medical information necessary to process insurance claims to determine payment for the related services. I understand that I am financially responsible for the deductible, co-insurance and non-covered services.

Financial & Managed Care Policies (Including Medicare)

Your insurance only pays for covered benefits. Some items and services are NOT covered benefits and your insurance will NOT pay for them. You are responsible to pay for uncovered benefits, personally or through any other insurance that you may have.

Your plan may NOT cover the following:

-Professional contact lens evaluation/fees (only covered by VISION insurance plans)
-Routine eye examinations
-Refraction* (only covered by VISION insurance plans)

I understand I am fully responsible for non-covered services AND payments are due at time of service.

I understand that I may be billed for services rendered & may appeal my insurance's payment decision.

Signature: _____ **Date:** _____

**What is a Refraction?* A refraction is a medical test to determine your glasses/contact lens prescriptions and measure your best corrected vision – this cannot be determined without a refraction. The refraction is used to determine ocular changes, defects & refractive errors. A refraction may need to be performed more than once in a calendar year. Example: cataract surgery patients will have a refraction performed prior to surgery and then again after surgery. Refractions are not covered by most medical or Medicare plans & is covered once a year with a vision plan. You will be responsible for payment for each refraction.

Thank you for choosing EyeCare Plus for your family eye care!