# PATIENT INTAKE FORM

**PATIENT INFORMATION**

**Name:** _____ **Sex:** M | F **DOB**____/____/ _____

**Address**: _____ **City**: _____ **State**: _____**Zip:** _____

**Primary Phone**: _____ ☐ Mobile ☐ Home | **Secondary Phone**: _____ ☐ Mobile ☐ Home

**Email Address**: _____ *Permission to receive text or email notifications*: ☐ Yes ☐ No

**Emergency Contact:** _____ **Emergency Phone:** _____

**Individuals Authorized to Discuss Your Health Information**

**Name**: _____ **Phone**: _____ **Relationship to Patient**: _____

**Name**: _____ **Phone**: _____ **Relationship to Patient**: _____

**UNDERSTANDING MEDICAL/VISION INSURANCE COVERAGE**

Vision insurance provides benefits for routine examination of healthy eyes and helps pay toward prescription eyewear or contact lenses. Vision plans do **NOT** cover any part of an eye exam considered "medical." In contrast, medical insurance generally helps cover costs incurred due to eye injury or disease (e.g., vision loss, floaters, dry eyes, allergies, infections, cataracts, macular degeneration, complications from diabetes, etc.) Your doctor will inform you of any eye conditions that fall under your medical insurance coverage. **If any medical eye conditions are diagnosed that affect the examination and/or correction of your vision, your medical insurance WILL be billed in lieu of your vision insurance.**

**REFRACTION AND CONTACT LENS COPAYS**

Refractions, the test used to determine your glasses prescription, are typically covered under vision insurance as part of a routine exam, though a small copay may apply depending on your plan. However, if the nature of your visit is to manage medical conditions including ocular or systemic diseases (e.g., dry eye, red eyes, diabetes, cataracts, etc.) and the refraction is performed, your visit **will** be billed to medical insurance. Because your **vision and medical plans cannot both be billed on the same day of service, refractions are generally NOT covered by medical insurance and will incur a $75 out-of-pocket fee**. Similarly, contact lens evaluations and fittings are handled through vision insurance, which often includes a dedicated copay for these services—separate from your exam copay—to help offset costs for prescribing and verifying contact lenses. This fee covers the evaluation, follow-up visits to finalize the prescription, trial lenses and related materials. We encourage you to review your plan details or ask our team upfront to clarify these fees and avoid any surprises during your visit.

**RETINAL SCREENING**

As part of our commitment to early detection of ocular and systemic disease (including glaucoma, macular degeneration, diabetes, vascular disease, and other sight-threatening conditions) **our office performs high-resolution retinal** *(internal eye)* **photography every 1-2 years** during comprehensive vision exams, unless an exception applies*. This screening photo is equivalent to dental X-rays—essential for tracking subtle changes over time that are invisible without imaging. It is **faster**, **does not require eye drops,** and **improves the doctor's ability to detect and track eye diseases**. Note that imaging does **not** replace pupil dilation but aids in improved monitoring and detection and allows the doctor to assess the retina when dilation is not possible, contraindicated or declined. Many patients who choose retinal screening will not require pupil dilation; however, your doctor will determine if dilation is necessary based on your specific conditions or concerns. **Cost & Coverage:** *$39 maximum out-of-pocket* for routine retinal screening. Most vision and medical plans consider this non-covered for routine exams.

***Exceptions**: Recent imaging from another provider (within the last 12 months), medical contraindications (e.g. epilepsy), financial hardship, or other. If any apply, please discuss with our team to see how we can accommodate you.

**Please choose <u>one</u> of the following:**

- ☐ **I consent to retinal screening**. *<u>Doctor recommended</u>*.
- ☐ **I decline retinal screening** today and **prefer to be dilated using eye drops**.
  *Note: Medicated drops can cause 4-6 hours of vision blur and light sensitivity—allowing the doctor to examine the retina.*
- ☐ **I decline <u>both</u> dilation drops and retinal screening**. I understand some conditions may go undetected without one of these evaluations.

**OFFICE PAYMENT POLICY**

Payment on deductibles, co-payments, and non-covered charges are due at the time of service. We accept cash, checks, debit cards, Visa, Mastercard, American Express, Discover, Flex Spending cards and HSA. ***I authorize* release** of information necessary to process any claims for services received in this office. *I further authorize* payment for any claims to be made to this office. I understand the office billing policies as listed above and agree that *I am financially responsible* for co-pays, deductibles, and fees not paid for by my insurance:

X _____ _____

Patient/Guardian Signature Date

**PATIENT ACKNOWLEDGMENT OF PRIVACY PRACTICES**

I hereby acknowledge that **I have received and reviewed** a copy of this office's **Notice of Privacy Practices**. I understand the notice of Privacy Practices may be reviewed from time to time and that I am entitled to receive a copy of revised Notice of Privacy practices upon request.

X _____ _____

Patient/Guardian Signature Date

## PATIENT MEDICAL HISTORY

**Name:** _____ **Date**_____/_____/_____

**Reason for Today's Exam:** _____ **Years Since Last Eye Exam:** _____

**Currently Use**: ☐ Glasses ☐ Soft Contacts ☐ Specialty Contacts ☐ None **Interested In**: ☐ Glasses ☐ Sunglasses ☐ Safety Glasses ☐ Contacts

**Primary Care/Referring Provider:** _____ **Clinic:** _____ **Phone:** _____

**Diagnosed Medical Conditions:**

☐ Arthritis ☐ Autoimmune: _____ ☐ Cancer ☐ Diabetes: [ **Type 1** OR **Type 2** ] Current HbA1C: _____% Blood Sugar _____mg/dL

☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Kidney Disease ☐ Multiple Sclerosis ☐ Stroke/TIA ☐ Thyroid ☐ Other: _____

**Current Medications** (please list dosage if known)

| | | | |
|---|---|---|---|
| **1.** | **3.** | **5.** | **7.** |
| **2.** | **4.** | **6.** | **8.** |

**Previous Surgeries:** ☐ Refractive (LASIK | PRK | SMILE) ☐ Cataract ☐ Retinal ☐ Strabismus ☐ Other: _____

**Allergies:** please list allergic response [e.g. rash, hives, anaphylaxis, etc.] and severity of allergic reaction [e.g. mild, moderate, severe]

**Medication Allergies:**

☐ Penicillin ☐ Sulfa ☐ Other: _____

**Substance Allergies:**

☐ Pollen/Dander ☐ Latex ☐ Other: _____

### EYE SYMPTOMS

*Are you experiencing any of the following symptoms?*

| | | |
|---|---|---|
| ☐ Glare | ☐ Pain/Soreness | ☐ Distance Blur |
| ☐ Headaches | ☐ Foreign Body | ☐ Near Blur |
| ☐ Light Sensitivity | ☐ Infection | ☐ Distortion |
| ☐ Tired Eyes | ☐ Itching | ☐ Double Vision |
| ☐ Burning | ☐ Mucous | ☐ Flashes |
| ☐ Dryness | ☐ Eyelid Droop | ☐ Floaters |
| ☐ Tearing | ☐ Redness | ☐ Fluctuation in Vision |
| ☐ Swollen | ☐ Sand/Gritty Feeling | ☐ Vision Loss |

### EYE DISEASES

*Have **you** been previously diagnosed with____?*

| | |
|---|---|
| ☐ Amblyopia (lazy eye) | ☐ High Risk Medications |
| ☐ Blepharitis | ☐ Macular Degeneration |
| ☐ Blindness | ☐ PVD (*floaters*) |
| ☐ Cataracts | ☐ Retinal Detachment |
| ☐ Color Blindness | ☐ Strabismus (*eye turn*) |
| ☐ Diabetic Eye Disease | ☐ Keratoconus |
| ☐ Dry Eye | ☐ Corneal Disease |
| ☐ Glaucoma | ☐ **Other:** |

### FAMILY EYE DISEASES

*Any blood relatives diagnosed with the following eye diseases?*

| | |
|---|---|
| ☐ Amblyopia (lazy eye) | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Blindness | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Cataracts | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Color Blindness | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Eye Tumors | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Glaucoma | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Glaucoma Suspect | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Macular Degeneration | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Retinal Detachment | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Strabismus (eye turn) | Sibling \| Parent \| Grandparent \| Other: |

### FAMILY SYSTEMIC DISEASES

*Any blood relatives diagnosed with the following?*

| | |
|---|---|
| ☐ Arthritis | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Cancer | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Diabetes | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Heart Disease | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Hypertension | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Kidney Disease | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Lupus | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Stroke | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Thyroid | Sibling \| Parent \| Grandparent \| Other: |
| ☐ Other: | Sibling \| Parent \| Grandparent \| Other: |

### GENERAL HEALTH CONDITIONS

*Any conditions/symptoms that you are currently have or experience?*

☐ **General**: Fever | Weight Loss | Fatigue | Other:
☐ **Ears**, **Nose**, **Throat:** Ear Ache | Sinus Congestion | Other:
☐ **Cardiovascular:** High BP | Hypertension | Chest Pain | Other:
☐ **Respiratory**: Asthma | COPD | Shortness of Breath | Other:
☐ **Gastrointestinal**: Constipation | Diarrhea | Nausea | Other:
☐ **Kidney/Bladder/Genital:** Difficulty/Painful Urination | Other:
☐ **Muscles/Bone/Joint:** Arthritis | Muscle Pain | Other:
☐ **Skin:** Rash | Hair Loss | Skin Lesions | Other:
☐ **Neurologic**: Multiple Sclerosis | Migraine | Seizures | Other:
☐ **Psychiatric**: Anxiety | Depression | Mood Changes | Other:
☐ **Endocrine:** Diabetes | Thyroid Problems | Other:
☐ **Blood:** High Cholesterol | Anemia | Other:
☐ **Allergic/Immunologic:** Seasonal Allergies | Frequent infections | Other:

### SOCIAL HISTORY

*Have you formerly or do you currently?*

| | | | |
|---|---|---|---|
| Smoke | ☐ Yes | ☐ No | ☐ Former |
| Drink alcohol | ☐ Yes | ☐ No | ☐ Former |
| Use illicit drugs | ☐ Yes | ☐ No | ☐ Former |
| Regularly exercise | ☐ Yes | ☐ No | |
| Pregnant or Nursing? | ☐ Yes | ☐ No | |

**Lifestyle + Visual Requirements:**

Occupation: _____

Hobbies: _____

**LENSOMETRY (for administrative use only):**

OD: _____ - _____ x _____ OS: _____ - _____ x _____