



Patient Information

Patient Name _____ Today's Date ____ / ____ / ____
Address _____
City _____ State _____ Zip _____
Home Number (____) _____ Cell Number (____) _____
Email _____
Date of Birth ____ / ____ / ____ Social Security Number _____
Pharmacy _____
Referred by _____ Family Doctor _____

Emergency Contact Information

Emergency Contact _____ Relationship to Patient _____
Phone Number (____) _____

If you are the policy holder, please fill out only the bolded areas. Otherwise, please fill out every section.

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer
Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer



Financial Disclosure

FINANCIAL RESPONSIBILITY

Payment is expected in full at the time of service. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service. Although we will work with you during times of insurance transition, please understand that if we receive denials due to incorrect information or lapse of insurance coverage, you will be responsible for all charges in full. At the time of your visit, you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and any services that are not covered.

ACCEPTING INSURANCE

Our doctors are contracted with most medical insurance companies; however, we are not contracted with nor accept vision insurance. If your insurance requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company. Tertiary claims are filed as a courtesy but are patient responsibility.

REFRACTION SERVICE AND FEE

A necessary portion of a medical eye examination is a refraction as it determines the need for corrective eyeglasses, contact lenses and provides information when vision is blurry or increasingly changing. Medicare and most insurance companies do not cover this portion, so please be prepared to pay a \$85 refraction service fee in addition to your co-payment and/or deductible.

OPTOMAP RETINAL IMAGING

In order to provide the highest level of medical care, our doctors utilize state of the art retinal imaging equipment to obtain a panoramic image of the surface of your retina. These images help your doctor assess the health of your eyes and check for conditions including macular degeneration, glaucoma, and retinal detachments; problems can threaten vision without warning or symptoms. These images can also help your doctor detect serious health problems unrelated to the eye such as diabetes, hypertension, heart disease, some cancers, and auto-immune disorders. At present, Medicare and most insurance companies do not cover this type of retinal imaging, so please be prepared to pay a \$49 fee for this service.

RYZUMVI

Dilation-Reversal Drops are available as an optional, non-covered service. Patients may choose to purchase this drop for a \$20 fee, to shorten dilation recovery time. If elected, this product is an out-of-pocket expense and is not billable to insurance.

NO SHOW FEE

Any patient that does not provide at least a 24-hour notice prior to cancelling or reschedule their scheduled appointment will be charged a \$50 fee that will be applied to their account with AECC.



DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to health professionals or entities outside of Advanced Eye Care Center for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

I agree to the sharing of medical information with any family, friends, or others that I name below. If I do not agree, I will ask for a restriction request to limit sharing of my information. The sharing of medical information with family, friends or others does not give them permission to obtain copies of my medical record.

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

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient.

_____	Date ____ / ____ / ____
Signature of Patient or Authorized Person	

Relationship to Patient if the patient is not signing



Medical History Questionnaire

Patient Name _____

Primary Care Physician _____ Referring Physician _____

Please list all drug allergies

No known drug allergies

Allergy to	Reaction Severity		
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Past Eye History

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | |

Other _____

Eye Surgeries

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> No prior ocular surgery | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Trabeculectomy
(Glaucoma surgery) |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> RK | <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> LASIK | <input type="checkbox"/> Strabismus Surgery
(eye muscle surgery) | |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> PRK | | |

Other _____

Systemic Illnesses

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> No history of illnesses | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Eczema | <input type="checkbox"/> HIV | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headache | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | | | |

Other _____



Medical History Questionnaire

Please list all previous surgeries

Procedure _____ Year _____

Procedure _____ Year _____

Procedure _____ Year _____

Procedure _____ Year _____

Please list all medications you are taking including prescription, OTC, vitamins, topicals, supplements, and eye drops

Medication Name	Dosage and Frequency	Reason for Taking

Family History

- Diabetes Cataracts Macular Degeneration
 Blindness Glaucoma

Lifestyle Vision Assessment

- Do you wear glasses Yes No If yes: Driving Computer Reading
Do you wear contacts Yes No

Please check the following activities you do regularly

- Read newspaper/book Computer
 Cooking Playing Cards/Dominoes
 Art/Painting Golf/Tennis
 Nighttime driving Sewing/Needlepoint

If you are working, what is your occupation and some of your daily work-related tasks?

If you had to wear glasses or contacts after surgery, which activity would you be most willing to use them for?

- Reading Fine Print Computers TV/Driving

How would you describe your personality?

- Easy going In between Meticulous/Detailed

