ADVANCED EYE
CARE CENTER

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

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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 $30 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.

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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

ADVANCED EYE CARE CENTER

Medical History Questionnaire

Patient Name _____

Primary Care Physician _____ Referring Physician _____

Please list all drug allergies ☐ No known drug allergies

Allergy to	Reaction Severity
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe

Past Eye History

☐ Overall Healthy
☐ Amblyopia (Lazy eye)
☐ Aphakia
☐ Astigmatism
☐ Cataracts
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ Hyperopia (Far sighted)
☐ Iritis
☐ Keratoconus
☐ Macular Degeneration
☐ Myopia (Near sighted)
☐ Optic Neuritis
☐ Retinal Detachment

Other _____

Eye Surgeries

☐ No prior ocular surgery
☐ Blepharoplasty
☐ Cataract Surgery
☐ Corneal Transplant
☐ Foreign Body Removal
☐ Retinal Laser Surgery
☐ LASIK
☐ PRK
☐ Punctal Plugs
☐ RK
☐ Strabismus Surgery (eye muscle surgery
☐ Trabeculectomy (Glaucoma surgery)
☐ Vitrectomy

Other _____

Systemic Illnesses

☐ No history of illnesses
☐ Anemia
☐ Arthritis
☐ Arrhythmia
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Thyroid Disease
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes
☐ Eczema
☐ Fibromyalgia
☐ Headache
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Migraine
☐ Polymyalgia
☐ Psychiatric Disorder
☐ Skin Cancer
☐ Stroke

Other _____

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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

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Medication List Continued:

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

Medication Name	Dosage and Frequency	Reason for Taking