Current Medical and Eye History

Name _____ Age _____

Do you take any medications? Yes / No

Please list: _____

Are you allergic to any medications? Yes / No

Please list: _____

Were you referred to us by someone? Yes / No

Please list: _____

Do you or a blood relative have any of the following?			
	Yes (self)	**Yes** (family)	**No**
Glaucoma			
Blindness			
Diabetes			
Heart Condition			
High blood pressure			
Thyroid problem			

Do you have any of the following?		
	Yes	**No**
Blurry vision		
Double vision		
Glare		
Flashes		
Floaters		
Eye pain		
Red eyes		
Itchy eyes		
Burning eyes		
Stinging eyes		
Watery eyes		
Dry eyes		
Eye ache		
Eye swelling		
Do you currently wear contact lenses?		
Is today's visit for contact lenses? **		

**** Additional fees for contact lens fitting and evaluation apply. Depending on your insurance, you may be asked to pay for the contact lens portion of your exam today.**

We now perform the Optomap Retinal Exam on all our patients, every year.

The Optomap provides a non-invasive, full and detailed view of the inner eye. It allows us to diagnose eye disease at the earliest stages, does not require pupil dilation and make for a better and more complete annual eye examination. Additionally, your image files will be archived for future use allowing us to provide better long term eye care for you.

There is a $39 charge for this procedure that is not covered by insurance. We believe it is valuable beyond this expense. If you need to decline this service please let a staff member know.

Thank you,

Susan Miller, O.D.

By initialing here you acknowledge that you have read the above. _____

We cannot accept every insurance plan, please discuss insurance arrangements with our office staff before your exam.
Professional fees are due upon completion of service and are non-refundable.
We accept Visa and MasterCard. returned checks are subject to a $20 service charge.

Contact, Billing And Insurance Info.

Patient Information

First Name | M.I. | Last Name | Birthdate

Address

Phone Numbers

Home

Other

email address

Billing Information

Who is the person responsible for charges not covered by insurance?

❑ Self ❑ Parent ❑ Spouse ❑ Other

Name ❑ Same As Patient

First | M.I. | Last Name | Home Phone

Address ❑ Same As Patient

Social Security Number

Your Social Security Number is protected under the Federal HIPPA laws, and is required for billing purposes.

Employer | Work Phone

Insurance Information

Vision Insurance Info.

Policyholder's Name/Primary Insured

Plan Name

Medical Insurance Info.

Policyholder's Name/Primary Insured

Plan Name

This Space For Office Use

Insurance SOF? ❑ No ❑ Yes NPP SOF? ❑ No ❑ Yes

Signature Page

Notice of Privacy Practices (NPP):

Westminster Eye Associates' Notice of Privacy Practices (NPP) is posted at the front desk and we offer copies that you may keep. You can get a copy from the front desk or request a copy from any staff member. You are not required to read or keep it, but the Federal Government requires us to have them available for you.

"I have received, been offered, declined or had a copy of this NPP made available to me"

Please Sign:_____ Date: _____

Insurance Signature on File:

I request that payment of authorized Insurance benefits be made on my behalf to Westminster Eye Associates, for goods and services furnished me by Westminster Eye Associates.

Westminster Eye Associates accepts the charge determination of the Insurance carrier as the full charge, and I agree to be responsible only for the deductible, co-insurance and noncovered services. (Co-insurance and deductible are based upon the charge determination of the Insurance Carrier.)

I understand that Westminster Eye Associates will charge a late fee if my responsible portion of the bill (as described above) becomes 30 days or more past due. If my responsible portion remains unpaid beyond 90 days, additional charges, legal fees and collection fees will be assessed and collections and legal action taken.

I also understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim.

Please Sign:_____ Date: _____