Eye Love Smiles Eye & Dental Care (eye care)

Welcome To Our Office - All information is kept confidential!

Last Name _____First Name_____

Address_____City_____State_____Zip_____

Date of Birth_____/_____/_____ Sex: M F Marital Status: S M W D SSN_____

Home Phone_____ Daytime #_____ Cell #_____

Email address_____Occupation_____

How did you hear about us? Insurance Website Yellow Pages Referral / By Whom_____

***Medical / Insurance Information (MUST BE COMPLETED)**

Medical Insurance_____ ID #_____

Vision Plan_____ID #_____

***Primary Insured**_____Relationship_____

***Insured's Birth date**_____Insured's SSN_____Employer_____

Last Physical: Dr._____Date_____ Last Eye Exam: Dr._____Date_____

Reason for today's visit?_____

Do you wear glasses? Y N Have you ever worn contact lenses? Y N Have you ever had eye surgery? Y N

Do you experience? Blurred Vision Double Vision Dryness Tearing Migraines Eye Pain Redness

Burning Itchy Eye Fatigue Light Sensitivity Sand / Gritty Vision Loss Reduced Night Vision Floaters

Flashes Other_____

List all medications (Please include OTC, Vitamins and BCP's)_____

_____

Have you ever had an adverse drug reaction? Y N If yes, what medication?_____ Are you pregnant? Y N

***Patient / Family History (Self / Family)**

Blindness	S	F	Allergies	S	F	Heart Disease	S	F	Migraine	S	F
Cataracts	S	F	Anemia	S	F	Hepatitis	S	F	Pituitary	S	F
Cross Eye	S	F	Arthritis	S	F	High Cholesterol	S	F	Sinus Trouble	S	F
Glaucoma	S	F	Asthma	S	F	Hormonal	S	F	Stroke	S	F
Amblyopia	S	F	Cancer / Tumors	S	F	Hypertension	S	F	Thyroid Trouble	S	F
Macular Degen.	S	F	Diabetes	S	F	Kidney Disease	S	F	Weight Gain / Loss	S	F
Retinal Disease	S	F	G I / Digestive	S	F	Lupus / MS	S	F	Other		

***Social History**

Do you smoke? Y N Drink Alcohol? Y N Other substances? Y N Have you been exposed to Hepatitis or any STD's? Y N

Responsible Party_____Date_____

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____DOB:_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our service, and to conduct healthcare operation involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Eye Love Smiles Eye & Dental Care.

Patient or Legally Authorized Individual's Signature_____Date_____

FINANCIAL POLICY

I acknowledge that I am financially responsible for insurance co-pays, coinsurance and deductibles, along with all non-covered charges considered optional and/or not covered by my insurance carrier. I understand the payment is required at time of service, unless prior arrangements have been made.

Private Pay: If you have no insurance coverage or insurance we do not participate with, full payment is expected at the time of service.

Insurance Co-payments: Insurance co-pays are paid at the time of service. We do not bill co-pays.

Returned Checks: A $30.00 service fee will be assessed for returned checks.

Collections: Once an account is placed in *"Collection Status"*, all future services must be paid in full at the time of service. Any balance that is assigned to a collection agency will be assessed a 40% fee to cover the collection expense.

Patient or Legally Authorized Individual's Signature_____Date_____

BILLING POLICY

Because patients often have both medical and vision insurance, it is important to understand the differences.

Vision Insurance

- covers routine eye examinations only
- helps pay for glasses or contact lenses

Medical Insurance

- covers exams where any medical condition that can affect the eyes is evaluated such as
  - diabetes
  - high blood pressure
  - taking high risk medications
  - eye diseases
  - injuries
  - cataracts
  - allergies
  - dry eye
  - infections (pink eye, conjunctivitis, etc)

Should a medical test be performed the same day as my annual vision exam, I understand and accept financial responsibility for the following: (Please initial)

_____ Verification: Eye Love Smiles Eye & Dental Care is listed as a "participating" provider" for medical services.

_____ I understand there may be multiple claims billed to insurances that reflect the same date of service.

_____ I understand medical testing will be billed to my medical insurance. My patient responsibility for the medical charges remain pending until the Insurance Explanation of Benefits is received and has been posted to my account.

Patient or Legally Authorized Individual's Signature_____Date_____

Digital Retinal Photography

Just as dentists use X-rays to aid in diagnosing health conditions, our office provides a comparable level of care with digital retinal photos. The photo is quick, easy and comfortable.

We strongly recommend a photo for patients who are/have: (please check)

__a new patient
__never had retinal photos taken before
__sees spots and/or flashes
__is diabetic (or has a family history of diabetes)
__has high blood pressure (or has a family history of high blood pressure)
__macular degeneration (or has a family history of macular degeneration)
__glaucoma (or has a family history of glaucoma)

Benefits:

1. High resolution digital image of the back of your eye
2. Image becomes a permanent medical record allowing us to monitor for future changes
3. Aids in early diagnosis of diseases

Generally insurance does not cover the $39 fee of routine retinal photos. As a result you will be responsible.

_____I accept.
_____I decline.
_____I want to speak to the doctor to learn more before deciding.

Patient Signature:_____Date_____

For Contact Lens Patients ONLY (2/2016)

- Please be advised that a contact lens exam is not included in the cost of a comprehensive eye health/eyeglass exam
- Your contact lens exam is considered a separate exam procedure and is billed accordingly.
- Contact lens exam fees are due on the same day as the fitting. There is a **30 day** time limit if you opt to return on another day for the fitting. Fees include diagnostic lenses and follow up appointments within a **60 days** of the initial exam.
- Please note your insurance may discount the fitting fee.

new patients OR returning patients being fitted for the first time	**returning patients already fitted for contact lenses in this office**
Soft Contact Lenses Spherical $90 Astigmatism/Toric $115 Bifocal or Monovision $150	Soft Contact Lenses Spherical $75 Astigmatism/Toric $95 Bifocal or Monovision $115
Rigid Gas Permeable Spherical $100 Bi-Toric $150 Bifocal or Monovision $175	Rigid Gas Permeable Spherical $85 Bi-Toric $110 Bifocal or Monovision $120
Speciality Fit (ex: keratoconus, hybrid or scleral lenses) $250+	Speciality Fit (ex: keratoconus, hybrid or scleral lenses) $250+

I am aware of the fees listed above.

Signature_____Date_____