PATIENT INFORMATION

First Name: __________________ **MI**: ______ **Last Name**: ___________________ **Nick Name**: ____________

Address: _______________________________ **City**: ________________ **State**: ________ **Zip**: ___________

PHONE NUMBERS

Date of Birth: ____/______/______

Please ☑Your Preferred Contact Number

☐ **Cell**: _______________________

Sex: M ☐ F ☐

☐ **Work**: _____________________

Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

☐ **Home**: _____________________

Social Security # ________/_________/________

Email Address: __________________________________

☐ **Employed** ☐ **Retired** ☐ **Student**

Employer / School_____________________________ **Occupation / Grade**______________________________

If patient is a child, name of Parent(s)/ Guardian _______________________________ **Relationship** __________________

Emergency Contact: _____________________**Phone**___________________**Relationship**_________________

Who is your Primary Care Medical Doctor? ____

Last Eye doctor? (If not at 20/20 Vision Center) __________________**How long ago?** ________________

Do you currently wear Contact Lenses? ☐ **Yes** ☐ **No** **If yes, what brand do you wear?** __________________

Height: _______**ft.** _______**in.** **Weight:** __________ **Have you had Flu Shot this year?** ☐ **Yes** ☐ **No**

Tobacco Use: ☐ **Never a Smoker** ☐ **Current Smoker (Every Day)**
☐ **Former Smoker** ☐ **Current Smoker (Occasional)**

Alcohol Use: ☐ **None** ☐**Occasional** ☐**Socially** ☐**Moderately**

Women Only: **Are you currently Pregnant and/or Nursing?** ☐ **Yes** ☐ **No**

Does THE PATIENT experience any of the following?:

Flashes of light ☐ **Yes** ☐ **No**
Itchy/ Scratchy ☐ **Yes** ☐ **No**
Floating Spots ☐ **Yes** ☐ **No**
Watery Eyes ☐ **Yes** ☐ **No**
Dryness ☐ **Yes** ☐ **No**

Have you had any Eye Surgeries? □ **Yes** □ **No** **If Yes, What Kind?** ___________________________________
Please list any Over the Counter Eye Drops that you are currently taking ______________________________
Please list any Prescription Eye Drops that you are currently taking __________________________________

*****PLEASE TURN OVER & COMPLETE THE BACK*****

✸**Patient Initials** ______________

Allergic to medication: ☐ Yes ☐ No (If yes, please list all current drug allergies)

____

Medications: ☐ Yes ☐ No (If yes, please list all medications you are currently taking)

____

____

FAMILY HISTORY :	RELATIVE (Select All that Apply) :	Please Circle
Glaucoma	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Macular Degeneration	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Retinal Disease	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Cataracts	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Diabetes	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
High BP / Hypertension	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Thyroid	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Heart Disease	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Cancer	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)
Lazy Eye	☐None ☐ Mom ☐ Dad ☐ Sibling ☐ Grandparent	(Paternal / Maternal)

PATIENT HEALTH HISTORY Place an x mark on "yes" or "no" to indicate if you currently have any of the following:

General

☐ Yes ☐ No **Fatigue**
☐ Yes ☐ No **Weight Loss**
☐ Yes ☐ No **Weight Gain**

Ear, Nose, Throat

☐ Yes ☐ No **Allergies**
☐ Yes ☐ No **Sinus Problems**
☐ Yes ☐ No **Chronic Cough**
☐ Yes ☐ No **Dry Throat / Mouth**
☐ Yes ☐ No **Hearing Loss**

Respiratory / Pulmonary

☐ Yes ☐ No **Asthma**
☐ Yes ☐ No **Bronchitis**
☐ Yes ☐ No **Emphysema**
☐ Yes ☐ No **COPD**

Eye Problems

☐ Yes ☐ No **Glaucoma**
☐ Yes ☐ No **Macular Degeneration**
☐ Yes ☐ No **Cataracts**
☐ Yes ☐ No **Retinal Disease**
☐ Yes ☐ No **Lazy Eye**

Cardiovascular

☐ Yes ☐ No **High BP/Hypertension**: **If Yes, Year Diagnosed**? _______________
☐ Yes ☐ No **Heart Surgery**
☐ Yes ☐ No **Vascular Disease**

Gastrointestinal

☐ Yes ☐ No **Crohn's Disease**
☐ Yes ☐ No **Liver Disease**
☐ Yes ☐ No **Reflux**
☐ Yes ☐ No **Ulcer**

Endocrine

☐ Yes ☐ No **Diabetes Type 1 or 2?**______
If Yes, Year Diagnosed______ A1C LvL_____
☐ Yes ☐ No **Thyroid (Hypo / Hyper)**
☐ Yes ☐ No **Grave's Disease**

Musculoskeletal

☐ Yes ☐ No **Arthritis**
☐ Yes ☐ No **Swelling**

Skin

☐ Yes ☐ No **Psoriasis**
☐ Yes ☐ No **Skin Cancer / Melanoma**

Blood / Lymph

☐ Yes ☐ No **Anemia**
☐ Yes ☐ No **Cholesterol**
☐ Yes ☐ No **Bleeding Problems**

Neurological / Psychiatric

☐ Yes ☐ No **Headaches**
☐ Yes ☐ No **Seizures**
☐ Yes ☐ No **Dementia**
☐ Yes ☐ No **Anxiety**
☐ Yes ☐ No **Depression**
☐ Yes ☐ No **Epilepsy**
☐ Yes ☐ No **Stroke**

Allergic / Immunologic

☐ Yes ☐ No Herpes Simplex
☐ Yes ☐ No AIDS / HIV
☐ Yes ☐ No Lupus
☐ Yes ☐ No Rheumatoid
☐ Yes ☐ No Allergy Shots

Cancer

☐ Yes ☐ No
TYPE ______________________
Date of Onset ______________

✸**Patient Initials** __________________

OFFICE POLICIES

We are committed to offering the best and most thorough care possible. Please review policies listed below, as they are important to understanding the services offered at our office, how your payments are processed and how your insurance is billed.

Professional fees are due at the time services are rendered. Payment is required when an order for glasses or contacts is placed. Professional fees are non-refundable. We accept Visa, MasterCard, Discover, Care Credit, and checks with valid identification. We also accept assignment on many types of insurance.

CONTACT LENS POLICIES

Contact lenses are medical devices that require a comprehensive vision and eye health evaluation before they are prescribed. If contact lenses are appropriate for you, follow-up medical management is required. We will release your prescription to you after the doctor has determined that the contact lenses meet all the criteria for proper eye health and visual acuity specific to your case. If you are unable to adapt to your contact lenses, you have within 90 days the option to change to a different type of contact lens and pay the difference should there be any. No cash refunds will be given, only office credit with the return of contact lenses in good condition. Credit will be given for unopened boxes of contact lenses.

RETURNED CHECK POLICY

Any check returned to us as insufficient funds shall be charged a $30 service fee in addition to the value of the check.

EYEWEAR WARRANTY POLICY

We are committed to following the eyewear warranties set forth by the frame and lens manufacturers, labs and insurance companies for all product lines that are carried at 20/20 Vision Center. Warranty information is available upon request.

ALL SALES FINAL POLICY

20/20 Vision Center strives for prompt service. For that reason, your eyewear order is placed with the labs and frame companies as soon as you place your order with 20/20 Vision Center. This is a completely personalized type of order and made just for the patient. Once your order is placed and production has begun, there is no way to reverse or stop that order. For this reason all eyewear sales are final at the time of purchase and there are no refunds.

HEALTH INSURANCE AND VISION INSURANCE POLICIES

There are two types of health insurance that will help pay for your eyecare services and products. You may have both and our practice accepts both:

1. Vision Care plans (Such as VSP, EyeMed, Davis Vision, Spectera, Community Eyecare, and Superior Vision)
2. Medical Insurance (Such as Medicare, BCBS, Aetna, Medcost, United Healthcare, Cigna, Etc…)
   - Vision Care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

- Medical insurance must be used if you have any eye health problems or a systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, you will be responsible for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Your vision insurance plan may also provide nominal coverage for frames, spectacle lenses, and/or contact lens evaluations and supply.

We do our best to verify insurance eligibility prior to any rendered services, so that we are able to notify you of any areas of concern prior to your appointment. Vision insurances have a large number of different vision plans with varying copays, exam coverage, material coverage, fee schedules, and eligibility dates.

If you have any questions regarding your eligibility for any services or materials, we will assist you as much as possible and provide as much information as we are able to attain. However, we strongly encourage you to research your insurance coverage thoroughly – vision care plans provide member information that can be accessed on their respective websites or by calling their member information phone lines.

In some cases, the doctor may request a follow-up evaluation to your comprehensive eye exam based on a particular diagnosis or prescription that is slightly more involved. These visits are not covered by vision insurance, and payment for these services is expected at the time services are rendered. Your medical insurance may help cover these visits. You may ask the doctor if you have questions regarding the cost for this follow-up care.

Medical visits may include, but are not limited to, eye infections, eye-related emergencies, eye-related allergic reactions, and foreign body removal. The cost for these services, and any subsequent follow-up appointments, can often only be determined after the patient is evaluated by the doctor. For such visits and follow-up appointments, payment is expected at the time services are rendered. We encourage you to call our office or come in immediately when such medical conditions or emergencies arise, as we are often able to treat you in a timelier manner than your primary healthcare provider or any urgent care or emergency room.

Insurance Disclaimer: Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is processed and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

If you have any further questions regarding our office policies; your payments or insurance, our doctors and staff will assist you as much as possible.

Acknowledgement of Information

HIPAA Privacy Act:
Acknowledgement of Receipt of Notice of Privacy Practices

I, ____(Print full legal name here: the "patient" or "patients legal representative"), have been provided or have been given the opportunity to receive a copy of the Notice of Privacy Policy of 20/20 Vision Center.

Assignment of Insurance Benefits

I hereby assign benefits to be paid, on my behalf, to 20/20 Vision Center. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

Patient Referrals:

In the event that Dr. Morris, Dr. Weitzel or Dr. Davis refers me to another physician for my ocular health, I allow 20/20 Vision Center to fax my medical records to the authorized doctor.

Office Policies:

I have read and understand or have been given the opportunity to receive a copy of the office policies regarding payments and insurance billing (Including: Contact Lens Policies, Returned Check Policies, and All Sales Final policy for eyewear) for services rendered at 20/20 Vision Center.

(*Complete by parent/legal guardian only if the patient is under the age of 18*)

Printed Name: ____________________________________Social Security #______________________________

Relationship to Patient: ____________________________

Signature: ____Date:_______________________
(Patient, Parent, or Legal Patient Guardian)