VISIONAIRE
EYECARE

Patient Information

Full Name:_____ DOB:_____ Sex: **M** / **F** Date:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Occupation:_____

E-mail: _____

Who referred you to us? Name: _____ Phone: _____

Medical Information

Reason for today's exam:_____

Are you experiencing any medical problems with your eyes (i.e. dry eyes, itchy eyes, etc.) that you would like addressed?

Y / **N** If YES, please explain _____

Are you pregnant and/or nursing? **Y** / **N**

Allergies to any medications or Latex?_____

Do you wear contact lenses (CL)? **Y** / **N** Contact Lens info: **Soft** / **Hard** CL Brand: _____

Cleaning Solution:_____ How often do you sleep in your CL?_____

Do you have any systemic medical condition(s) such as **HIGH BLOOD PRESSURE and/or DIABETES**? Do you take any high-risk medications such as **Plaquenil, Methotrexate, Thorazine, Lithium, Tamoxifen**? **Y/ N** If **YES**, tell us immediately

Have you ever had an INFECTION, INJURY, or SURGERY affecting the **EYES** or **HEAD**? Please explain _____

_____

Are your eyes sensitive to sunlight? **Y** / **N** Do you have problems with reflections and/or glare? **Y** / **N** Do you sometimes experience dry eyes? **Y** / **N** Do you use digital devices i.e. computers, smart phones, HDTV's? **Y** / **N** Do you prefer not to wear your glasses at times? **Y** / **N** Would you be interested in newer contact lens technology? **Y** / **N** Would you be interested in LASIK vision surgical correction? **Y** / **N** Be interested in a *nonsurgical* option to LASIK? **Y** / **N** Please list your sports activities and hobbies _____

_____

Medical / Vision Insurance Information—If applicable (Please provide insurance card(s) to photocopy)

Name of Insured_____ Relation to Insured_____

Date of Birth of Insured_____ ID # of Insured_____

Medical/Vision Insurance Carrier_____ Insurance Group Number_____

I authorize Visionaire Eyecare to submit billing to my insurance company when applicable and I understand I may be responsible for any charges not covered by insurance.

_____

Signature of Patient or Representative

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Current medications, including dosage, frequency, and start date:_____

_____

Primary Care Physician:_____

Conditions you are currently being **TREATED** for:_____

Past **MEDICAL** conditions and/or **SURGERIES**:_____

Are you **EXPERIENCING** or have been **DIAGNOSED** and/or **TREATED** for any of the following below? Please **CHECKMARK** under YES/NO and circle the condition. If it isn't listed, please write in the row.

YES	NO	If **YES**, please **CIRCLE** the disease/symptom.
		Eyes: (Please CIRCLE which eye and EXPLAIN if applicable) ☐ Crossed Eye / Eye Turn **(R / L / Both)**_____ ☐ Double Vision **(R / L / Both)**_____ ☐ Dry Eyes **(R / L / Both)**_____ ☐ Eye Infections **(R / L / Both)**_____ ☐ Excess Tearing / Watering **(R / L / Both)**_____ ☐ Flashes of Light / Floaters **(R / L / Both)**_____ ☐ Glaucoma **(R / L / Both)**_____ ☐ Itchy Eyes **(R / L / Both)**_____ ☐ Lazy Eye **(R / L / Both)**_____ _ ☐ Macular Degeneration **(R / L / Both)**_____ ☐ Retinal Detachment or Disease **(R / L / Both)**_____ ☐ Stye **(R / L / Both)**_____ __ ☐ Tired Eyes / Eyestrain **(R / L / Both)**_____
		Constitutional: ▪ Developmental Disabilities ▪ Fever ▪ Fatigue Syndrome ▪ Other_____
		Ear, Nose, & Throat: ▪ Allergies ▪ Dry Throat / Mouth ▪ Hearing Loss ▪ Laryngitis ▪ Sinusitis
		Cardiovascular: ▪ Congestive Heart Failure ▪ Heart disease ▪ High Blood Pressure ▪ Vascular Disease ▪ Stroke
		Respiratory: ▪ Asthma ▪ Bronchitis ▪ Emphysema ▪ Lung Cancer ▪ Sleep Apnea ▪ Tuberculosis
		Gastrointestinal: ▪ Acid Reflux ▪ Cancer (Cervical / Ovarian / Prostate) ▪ Celiac Disease ▪ Colitis ▪ Crohn's Disease ▪ Kidney Disease ▪ Stomach Ulcer
		Musculoskeletal: ▪ Ankylosing Spondylitis ▪ Arthritis ▪ Fibromyalgia ▪ Gout ▪ Lupus ▪ Muscular Dystrophy ▪ Osteoporosis ▪Rheumatoid Arthritis ▪ Other_____
		Skin: ▪ Cold sores ▪ Eczema ▪ Psoriasis ▪ Rosacea ▪ Shingles ▪ Skin Disease
		Endocrine: ▪ Breast Cancer ▪ Diabetes (Type 1 / 2) ▪ Hormone Replacement ▪ Thyroid disorder
		Neurological: ▪ Autism Spectrum Disorder ▪ Cerebral Palsy ▪ Headaches / Migraines ▪ Multiple Sclerosis ▪ Seizures
		Psychiatric: ▪ Anxiety ▪ Attention Deficit Disorder ▪ Bipolar Disorder ▪ Depression ▪ Schizophrenia

		Blood & Lymph: ▪ Anemia ▪ Blood Cancer ▪ HIV / AIDS ▪ High Cholesterol ▪ Sjogren's Syndrome
YES	**NO**	**FAMILY HISTORY:**
		Does a BLOOD relative in your family have any of the following diseases? (**CIRCLE** all that apply) ▪ Blindness ▪ Cancer (Type: _____) ▪ Cataracts ▪ Diabetes ▪ Glaucoma ▪ High Blood Pressure ▪ Stroke ▪ Thyroid Disease ▪ Macular Degeneration ▪ Retinal Detachment
YES	**NO**	**SOCIAL HISTORY:**
		Does your current vision **LIMIT** any activities of your daily living? (**CIRCLE** all that apply) Driving ▪ Reading ▪ Sports ▪ Work ▪ Other _____
		Do you drink alcohol?
		Do you smoke? If **YES**, how much? _____ per day; how long? _____ year(s)

IMPORTANT INFORMATION FOR OUR PATIENTS

As a courtesy to our patients, our office will complete and submit VISION and/or MEDICAL insurance claims to your insurance company on your behalf. We will also assist you in obtaining the maximum insurance benefits. We greatly appreciate payment of any applicable copayments, coinsurance, and deductibles at the time of service. Please provide your insurance card(s) to our staff member.

About Your Insurance

There are two types of health insurances that will help pay for your eyecare services and/or products. You may have both and our practice accepts both. They are **VERY DIFFERENT** in what they cover and it is **IMPORTANT** that you understand the differences.

- **VISION** care plans (such as VSP) **ONLY** cover routine vision exams along with eyeglasses and/or contact lenses. They are designed to cover the determination of a glasses prescription and a routine evaluation of the health of the eyes in a healthy patient. They **DO NOT** cover diagnosis, management or treatment of eye diseases OR evaluations of medical concerns or complaints. **That is covered by medical insurance.**
- **MEDICAL** insurance (such as BlueCross/BlueShield or Medicare) **MUST** be used if you have any eye health problem or systemic health problem, such as **DIABETES** and/or **HIGH BLOOD PRESSURE**, that has a risk for ocular complications, OR if you are taking highrisk medications well known to cause medical eye problems (i.e. Plaquenil). Your doctor will determine if these conditions apply to you, but some are determined by your symptoms and/or health 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 outofpocket 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, we will bill you for any unpaid deductibles, copays or noncovered services as allowed by the insurance contract.

Please understand that these are the insurances rules, **NOT** ours. It is ultimately the **PATIENT'S RESPONSIBILITY** to read and understand their insurance benefits information in its entirety. As a courtesy, we will try our best to obtain your eligibility and benefits information from your insurance company prior to your exam. **We DO NOT guarantee benefits.** If insurance payment is not received in a timely manner, the entire balance is due from you. I clearly understand and agree that I am personally responsible for payment of all services and products rendered to me that is NOT covered by insurance. 1% interest will begin to be added on balances that are 30 days past due. I also agree to pay for ALL legal fees associated with the collection of payment, including a fee up to 25% of the balance owed should your account go to COLLECTIONS. Should you fail to show up on your scheduled appointment with us, without at least 24 hour notification, a $40 cancellation fee may apply which must be paid before any further services are rendered.

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HIPAA Notice of Privacy Consent

I understand that Visionaire Eyecare may use and disclose necessary personal & confidential health information (e.g., name, address, ID number, and/or eye exam info.) to another party to permit our office to perform its administrative duties, provide me with eye care services & products, process my vision/medical claims and communicate with me regarding vision/medical care services provided by this clinic. **I can be assured that Visionaire Eyecare does not sell my personal health information of any kind to a third party for such party's own use.** You may review our complete notice of Privacy Practices on our website at www.visionaireeyecare.com.

We would like to ask for your permission to be able to send your health information when necessary through regular email.

YES / NO

If not, with respect to HIPPA we will send your health information securely.

By signing below, I acknowledge that I have read, understand, and agree with all the information on this page and I wish to proceed with services at Visionaire Eyecare.

_____	_____	_____
Signature (Patient or Legal Representative)	PRINT NAME	Date