Visionary Eyecare

Last Name_____ First Name_____ MI_____ DOB:___/___/_____

Date___/___/_____ M or F SSN:___/___/_____ Marital Status: Married / Single / Divorced / Widowed

Birth State:_____ Sports/Hobbies:_____ Mother's Maiden Name: _____

Race: American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, White, Other Race, Decline **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline

Height:_____ Weight_____ Preferred Language: English / Spanish / Other:_____

Address: _____ City: _____ State:_____ Zip:_____

Home Ph:( )_____-_____ Work Ph:( )_____-_____ Ext: ____ Cell Ph:( )_____-_____

Employer/School: _____ Occupation/ School Grade: _____

E-mail Address:_____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail

Emergency Contact:_____ Relation:_____ Phone #:( )_____-_____

Mother's Name: _____ SSN:_____/____/_____

Address if different:_____

Father's Name: _____ SSN:_____/____/_____

Address if different:_____

How did you hear about our office?_____ Are you currently pregnant or nursing? Yes / No / N/A

Date of Last Medical Exam:___/___/_____ Primary Physician/Clinic:_____

Address:_____ Phone( )_____-_____

Date of Last Eye Exam:____/___/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Reading only / Driving only

How old are your present glasses? _____ years Do you wear prescription Sun Wear? Yes/No

Are you interested in contacts? Yes / No Do you wear contacts? Yes / No Type:_____

Solution Used:_____ Wearing schedule: **Daily Overnight**

Replacement Schedule: **Daily / 2 week / Monthly / Yearly** Are you interested in LASIK? Yes / No

Have you ever had an eye injury? Yes / No : Right / Left

Have you ever had eye surgeries? Yes / No Why?_____

Have you used eye medication? Yes / No Why?_____

Have you ever been diagnosed with?

Cataracts: Yes / No When were you diagnosed? _____

Glaucoma: Yes / No When were you diagnosed? _____

Macular Degeneration: Yes / No When were you diagnosed?_____

What are your visual symptoms today: Please circle any that apply:

Please indicate Right, Left, or Both, along with severity 1(Low) 2(Moderate) 3(High)

[ ]Blurred Vision/Distance	R L B	[ ]Dry Eyes	R L B	[ ]Headaches	R L B
[ ]Blurred Vision/Near	R L B	[ ]Red Eyes	R L B	[ ]Migraine Headaches	R L B
[ ]Double Vision	R L B	[ ]Watery Eyes	R L B	[ ]Loss of Vision	R L B
[ ]Eye Strain	R L B	[ ]Wandering Eye	R L B	[ ]Crossed Eyes	R L B
[ ]Eye Infections	R L B	[ ]Mucus Discharge	R L B	[ ]Light Sensitive	R L B
[ ]Eye Pain/Soreness	R L B	[ ]Floaters or Spots	R L B	[ ]Gritty Feeling	R L B
[ ]Tired Eyes	R L B	[ ]See Flashes	R L B	[ ]Poor Color Vision	R L B
[ ]Burning Eyes	R L B	[ ]See Halos	R L B	[ ]Droopy Lid	R L B
[ ]Itchy Eyes	R L B	[ ]Poor Night Vision	R L B		

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK ANY OF THE FOLLOWING THAT **APPLIES** TO YOU, AND LIST ANY MEDICATION FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __None __Hypertension (High Blood Pressure) __High Cholesterol __Stroke __Heart Disease Other:	**Endocrine:** __None __Non-Insulin Dependent Diabetes __Insulin Dependent Diabetes __Thyroid Problem __Hormonal Dysfunction Other:	**Respiratory:** __None __Asthma __Bronchitis __Emphysema __COPD Other:
Constitutional: __None __Cancer __Trauma/Large Volume Blood Loss __Developmental Disability Other:	**Ocular:** __None __Glaucoma __Macular Degeneration __Detached Retina Other:	**Psychiatric:** __None __ADHD __Depression __Schizophrenia Other:
Neurological: __None __Multiple Sclerosis __Epilepsy __Cerebral Palsy __Tumor Other:	**Musculoskeletal:** __None __Osteoarthritis __Fibromyalgia __Muscular Dystrophy __Ankylosing Spondylitis Other:	**Immunologic:** __None __AIDS or HIV __Rheumatoid Arthritis __Lupus __Neurofibromatosis Other:
Hematological: __None __ Anemia __ Leukemia Other:	**Gastrointestinal:** __None __Crohn's __Colitis Other:	**Ear/Nose/Throat:** __None __Hearing Loss __Upper Respiratory Infection Other:
Dermatologic: __None __Eczema __Rosacea __Psoriasis Other:	**DrugAllergies:**(please list) __None Environmental Allergies:	**Alcohol Use:** **Yes / No** Amount: **Tobacco Use:** **Yes / No** Amount:

Please list physical reactions to above allergies: _____

Please list any medications and/or drugs that you are taking (including herbal): See Attached List: _____

1		For:	6		For:
2		For:	7		For:
3		For:	8		For:
4		For:	9		For:
5		For:	10		For:

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE/ CONDITION					
Retinal Detachment:	Y / N		Blindness:	Y / N	
High Blood Pressure:	Y / N		Cataracts:	Y / N	
Diabetes:	Y / N		Glaucoma:	Y / N	
Cancer:	Y / N		Crossed Eyes:	Y / N	
Heart Disease:	Y / N		Macular Degeneration:	Y / N	
Thyroid Disease:	Y / N		Lupus	Y / N	

Reviewed by:

Dr_____ Date:_____

HIPAA Authorization Form

Patient's Full Name	Parent's Full Name
Address	Patient's Date of Birth
City, State, Zip Code	Patient's Phone Number

I have received or was offered and declined a Notice of Privacy Practices for Visionary Eyecare of Monroe.

1. I authorize Visionary Eyecare of Monroe to use or disclose personal health information about me to the following:

   NAME: _____

   NAME: _____

   NAME: _____

2. I understand that the information used or disclosed may be subject to re-disclosure by the person/class of persons or facility receiving it, and would then no longer be protected by Federal Privacy Regulations.
3. I may revoke this authorization by notifying Visionary Eyecare of Monroe in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that my insurance company gives Visionary Eyecare an estimate of coverage, and that I am ultimately responsible for all charges incurred for myself and dependents.
5. I give Visionary Eyecare permission to bill and receive direct payments on behalf of services for myself and dependents.

FEES FOR COPIES: Federal and State laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed to you along with an invoice.

~THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING~

X _____ _____

Signature **Date**

X _____ _____

Signature(s) of Guardian(s)/Representative(s) **Date**

Relationship to Patient: _____

Understanding Your Medical and Vision Insurance

There are two ways of categorizing an eye examination. Your eye examination may be defined as either **"Routine"** or "Medical". The type of examination is determined by the *reason for your visit* as well as your *diagnosis* as determined by the doctor. Routine eye examinations are typically filed with vision insurance and medical eye examinations are filed with medical insurance.

Vision Insurance is designed to cover routine eye examinations. A routine eye examination takes place when you come for an eye examination without any medical eye problem and there are *no symptoms* except for visual changes that can be corrected by eyeglasses or contact lenses. In addition, the doctor screens the eyes for disease and finds *no medical problems*. Also performed during the routine eye examination is a separate test called a refraction. This is a measurement the doctor uses to determine the best correction to provide your eyes with the clearest vision possible and results in the determination of your eyeglass prescription. This test can also provide the doctor with information regarding your eye health and can help the doctor detect eye diseases. Typically, vision insurance plans will cover the routine eye examination and the refraction. Examples of vision insurance plans include: Vision Service Plan (VSP), EyeMed and Superior Vision.

Medical Insurance is designed to cover medical eye examinations. Your visit will be coded as a medical eye examination whenever you are being evaluated or treated for a medical condition or symptoms that you bring up or you are being evaluated or treated for a condition that the doctor finds during the examination or has been previously diagnosed. Examples that will necessitate your visit being submitted to your medical insurance include: eye irritation, red eyes, dry eyes, floaters, double vision, vision loss, diabetes, cataracts, glaucoma, glaucoma suspect, macular degeneration, and others. This type of eye examination will be submitted to your medical insurance plan. Many of these plans do not cover a refraction (the test to determine your eyeglasses prescription) or eyeglasses.

Example: Let's say you have both medical insurance and a separate vision plan, such as Vision Service Plan (VSP). You decide to see your eye doctor for your annual exam because you would like new eyeglasses. At the end of the examination your doctor informs you that in addition to a minor prescription change you have signs of glaucoma and you are instructed to return for further tests.

Your original reason for the visit was to get an eye examination and purchase new glasses. Although your doctor discovered a diagnosis of glaucoma suspect at the end of your exam, because you did not report any symptoms or complaints as the reason for your visit this visit would be submitted to your vision insurance plan. But at the end of that examination, you will be considered a glaucoma suspect. This is now a medical diagnosis, and *any further testing you have, including your next eye examination, must be billed as a medical examination to your medical insurance plan.*

In summary, how your eye examination will be submitted to your insurance carrier will depend not only upon what you tell your doctor, but also what he doctor finds upon examination. Regular eye examinations are important to maintain your vision and eye health for your lifetime. It is important that you are aware of your insurance benefits and how they apply to your visit, so you will know how the billing for your visit will be handled. Ultimately, it is your responsibility to know the details of your individual plans. If you have any questions, please ask a member of our staff and we would be happy to help you.

I have read and understand the above information and authorize Visionary Eyecare of Monroe to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Patient's Signature: _____ **Date:** _____

visionary eyecare of monroe

Your ***Vision*** is our ***Focus***

Thank you for allowing us to take care of your vision. As our mission is to care for all aspects of your complete eye health, please take a moment to help us better understand the visual world in which you live.

1. After how many hours on the computer do you begin to experience eye fatigue and/or eye strain?

_____ 1 hour
_____ 3 hours
_____ 5 hours
_____ More
_____ Never

2. Are you affected by distracting or annoying Glare while driving at night or in your daily commute?

_____ Often
_____ Sometimes
_____ Rarely

3. Would you be interested in the thinnest and lightest lenses available?

_____ Yes
_____ No

4. Do you spend time, either during the week or on the weekends, with outdoor activities?

_____ Often
_____ An average amount
_____ Rarely

5. Do your current sunglasses provide protection from harmful Ultra Violet A & B rays?

_____ Yes
_____ No
_____ Unsure
_____ Don't have

Name: _____

Date: _____

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www.VisionaryEyecareMonroe.com