

Welcome Back!

Date ___/___/___

Last Name _____ First Name _____ MI _____ DOB: ___/___/___
 M or F SSN: ___/___/___ Marital Status: Married / Single / Divorced / Widowed Birth State: ___
Height: ___ **Weight** ___ **Race:** White, American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, Other Race, Decline **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph:() _____ - _____ Work Ph:() _____ - _____ Ext: _____ Cell Ph:() _____ - _____
 E-mail Address: _____ Mother's Maiden Name: _____
 Employer/School: _____ Occupation/ School Grade: _____
 Sports/Hobbies: _____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail
 Emergency Contact: _____ Relation: _____ Phone #:() _____ - _____

What are your visual symptoms today: Please circle any that apply, and indicate which eye(s):

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

Please List anything in YOUR MEDICAL HISTORY not listed on your previous form.

Cardiovascular: _____ None ___ Stroke _____ Heart Disease ___ Hypertension _____ Other	Endocrine: _____ None ___ Diabetes _____ Thyroid ___ Diabetes Suspect _____ Other	Respiratory: _____ None ___ Asthma _____ COPD ___ Bronchitis _____ Other
Genitourinary: _____ None ___ Pregnancy _____ STDs Prostate Disorder _____ Other	Ocular: _____ None ___ Glaucoma ___ Detached Retina ARMD _____ Other	Psychiatric: _____ None ___ ADHD _____ Schizophrenia Depression _____ Other
Neurological: _____ None ___ Epilepsy _____ MS MD _____ Other	Musculoskeletal: _____ None ___ Arthritis _____ Fibromyalgia Osteoporosis _____ Other	Immunologic: _____ None ___ AIDS _____ Lupus RA _____ Other
Hematological: _____ None ___ Anemia _____ Leukemia Cancer _____ Other	Gastrointestinal: _____ None ___ Crohn's _____ Acid Reflux Colitis _____ Other	Ear/Nose/Throat: _____ None ___ Hearing Loss _____ Sinusitis Trauma _____ Other
Dermatologic: _____ None ___ Eczema _____ Rosacea Psoriasis _____ Other	Allergies to: _____ None Drug _____ Environmental _____	Alcohol Use: Yes / No Tobacco Use: Yes / No

Please List ALL MEDICATIONS you take: _____

Have you had any eye related injuries, diseases or surgery since your last visit? ___ Yes ___ No

Reviewed by: Dr _____ Date _____



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

Visionary Eyecare

Patient Financial Information Sheet

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

Signature of patient or parent if minor

Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: _____

Date: _____

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: _____