VISION BENEFIT MAXIMIZER

Patient Name:	**Appointment:**	**Time:**

Your minimum exam copayment today could be: Routine $_____ Medical $_____ Contact Fit $_____ (if applicable)

Final charges will be determined once your exam is completed

Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____ *Ask us about CareCredit!*

Date of Birth	Age	Home Address
Home Phone #		
Mobile #	Gender	Employer
Email Address	Occupation	

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Parent/Guardian Full Name	Relationship to Patient
Address	Primary Phone #

PRIMARY VISION INSURANCE	SECONDARY VISION INSURANCE
Insurance Carrier 1	Insurance Carrier 2
Policy Number	Policy Number
Group Number	Group Number

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Insurance Carrier 1	Insurance Carrier 2
Policy Number	Policy Number
Group Number	Group Number

POLICY HOLDER INFORMATION (IF DIFFERENT FROM THE PATIENT)

Policy Holder Name	Address
SSN	
Relationship to Patient	Primary Phone #
Date of Birth	Mobile Phone #

PRIMARY CARE INFORMATION

Physician Name	Phone #
Practice Name	Fax #

☐ **By checking this box I agree to have my records or diagnosis information shared with my physician.**

HIPAA PRIVACY NOTICE

The HIPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide at least one individual with whom we may share your medical records.

Authorized Individual _____ Phone Number _____

Authorized Individual _____ Phone Number _____

STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree I may be contacted at any number or address I have provided. I understand that my eye exam copayment is due today, and glasses or contact lenses may not be dispensed, if my exam is unpaid. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe. I understand that I am solely responsible for the cost of all non covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out of pocket. I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all claims if we are a participating provider for your plan. However, if my insurance denies payment for any claims submitted, I will be responsible for full payment. Otherwise, my eyecare provider will supply me with an itemized statement which I may submit to my insurance carrier.

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ Date _____

NAME: _____ DOB: _____ PHONE: _____

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you:

Breathing Problems	☐ Yes	☐ No	**Blood Disorder**	☐ Yes	☐ No	**Musculoskeletal Conditions**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	**Allergy/Immunology**	☐ Yes	☐ No	**Ear/Nose/Throat Problems**	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No	HIV*	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Endocrine Disorder	☐ Yes	☐ No	Lupus*	☐ Yes	☐ No	**Neurological Disorder**	☐ Yes	☐ No
Diabetes*	☐ Yes	☐ No	**Kidney/Bladder Problems**	☐ Yes	☐ No	Migraine Headaches*	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	**Surgical Operations**	☐ Yes	☐ No	Multiple Headaches*	☐ Yes	☐ No
Stomach Problems	☐ Yes	☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes	☐ No	Multiple Sclerosis*	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	**Cancer***	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	**Psychiatric Disorder**	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
High Blood Pressure*	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	Stroke*	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Depression	☐ Yes	☐ No	**Sexually Transmitted Diseases**	☐ Yes	☐ No

If you checked yes above, please briefly describe.

Have you had any eye injuries, eye surgeries, eye diseases, floaters or flashes of light?

Are you currently being treated for any other medical condition not listed above? If yes, please briefly describe.

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Please list any medications you are now taking. *(Including hormones, birth control, aspirin, or other anti-inflammatory, and eye drops)*

Is there any possibility that you might be pregnant? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

FAMILY HISTORY

Has anyone in your family had the following illnesses?

Blindness*	☐ Yes	☐ No	Relationship: _____
Cancer*	☐ Yes	☐ No	Relationship: _____
Cataract	☐ Yes	☐ No	Relationship: _____
Diabetes*	☐ Yes	☐ No	Relationship: _____
Glaucoma*	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
High Blood Pressure*	☐ Yes	☐ No	Relationship: _____
Macular Degeneration*	☐ Yes	☐ No	Relationship: _____
Other Eye Disease*	☐ Yes	☐ No	Relationship: _____
Respiratory Disease	☐ Yes	☐ No	Relationship: _____

*Additional testing may be covered through your medical insurance.