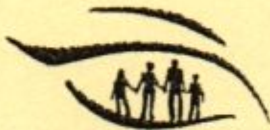
Patient Name: ___________________________________



Patient, Family, Social History

Your Past Ocular History:

Please CHECK any eye conditions listed YOU have had in the past.

Amblyopia	☐	Macular Degeneration	☐	Strabismus	☐
Cataracts	☐	Retinal Detachment	☐	Patching	☐
Glaucoma	☐	Retinal Degeneration	☐	Inflammatory Disorder	☐
Glaucoma Suspect	☐	Retinal Hole	☐	Eye Injury	☐
		Keratoconus	☐		

Other: ____ ☐

None ☐

Family Medical History:

Please CHECK the appropriate Family Member who has a history of the following conditions:

Family Ocular History:

Please CHECK the appropriate Family Member who has a history of the following conditions:

(Father, Mother, Brother, Sister, Son, Daughter)

	F	M	B	S	Son	D
Cancer						
Type 1 Diabetes						
Type 2 Diabetes						
Hypertension						
Hyperthyroidism						
Hypothyroidism						

	F	M	B	S	Son	D
Cataract						
Glaucoma						
Macular Degeneration						
Glaucoma						
Retinal Detachment						
Strabismus/Lazy Eye						

Social History, Patient:

Please answer the following questions.

Do you drink alcohol?	Yes	☐	No	☐	If YES, amount: ____________
Do you smoke?	Yes	☐	No	☐	If YES, amount: Packs/day ____________
Use chewing tobacco?	Yes	☐	No	☐	If YES, amount: ____________

Hobbies: ____

CONTACT LENSES:

Do you currently wear contacts? Yes ☐ No ☐ If YES, what kind? ____________

Are you interested in updating? Yes ☐ No ☐

How old are the contacts you are currently wearing? ____________

How many hours a day do your wear your contacts? ____________

How many hours have you worn your contacts today? ____________

How often do you replace your contacts? ____________

Do you sleep in your lenses? Yes ☐ No ☐ If so, how many nights? ____________

Patient Name: ______________________

Patient Medical History Form

Constitution

Fatigue Syndrome	
Fever	
Weight Loss	
Other	

ENT

Dry Mouth	
Hearing Loss	
Laryngitis	
Sinusitis	
Herpes/Cold Sores	
Other	

Neurological

Multiple Sclerosis	
Tumor	
Migraine	
Cerebral Palsy	
Stroke/CVA	
Epilepsy	
Other	

Psychiatric

Bipolar Disorder	
Depression	
Attention Deficit	
Anxiety Disorder	
Other	

Cardiovascular

Stroke/CVA	
Congestive Heart Failure	
Heart Disease	
Hypertension	
Vascular Disease	
Other	

Gastrointestinal

Colitis	
Ulcer	
Celiac Disease	
Crohn's Disease	
Acid Reflux	
Other	

Respiratory

Chronic Obstruction	
Bronchitis	
Asthma	
Cigarette Smoker	
Emphysema	
Sleep Apnea	
Other	

Hematologic

Ulcer	
Anemia	
Hypercholesterolemia	
Large Volume Blood Loss	
Other	

Musculoskeletal

Gout	
Muscular Dystrophy	
Osteoarthritis	
Ankylosing Spondyliris	
Other	

Integumentary

Psoriasis	
Rosacea	
Eczema	
Herpes Zoster/Shingles	
Other	

Endocrine

Hormonal Dysfunction	
Diabetes Type 1	
Diabetes Type 2	
Thyroid Dysfunction	
Other	

Allergy/Immunie

Lupus	
Sjogren's Syndrome	
Environmental Allergies	
Drug Allergies	
Rheumatoid Arthritis	
Other	

Genitourinary

Prostate Disease/Cancer	
Kidney Disease	
Other	

Medications: List all Medications you currently take: ______________________

____

____

____

Allergies: List all allergies: ______________________

____

Latex sensitivity? Yes ☐ No ☐

Complete Family Eyecare Patient Information Form

First Name:______________ Last Name: __________________Middle Init:____ Nickname:_______

If Under 18 years, Parent/Guardian's Name: ______________________________

Birth Date:___/___/_____ SS#_______-_______-_______

Race: All Other Races / American Indian or Alaska Native / Asian / African American /
Native Hawaiian or other Pacific Islander / White

Address:_________________________City:______________________State:_____ Zip Code:______

Phone: Home___________________ Cell___________________ Work_______________ Ext:____

Email Address:__________________________________

Marital Status: Married_________ Single:_________ Other:_________

Employer/School:______________________ Occupation/Grade:____________________ Retired:_____

Emergency Contact_________________________ Relationship_________ Phone number____________

Family Physician___________________ Office Location_____________________ Phone__________

Pharmacy_________________________ Phone____________________ Fax_____________________

Certain information is necessary to bill your claims correctly
If your coverage is under a Spouse or Parent's policy, we require the Primary Insured's Name, SS#, DOB, & Place of Employment.
If you have Medicaid and the card states (TPL) after your name, you must also present the primary insurance information.

VISION INSURANCE: __________________________ Plan Name:_________________________

Policy Holder: _____________________________ Date of Birth: ___________SS#________________

Policy Number: _____________________________Patient's Relationship to Policy Holder: ___________

MEDICAL INSURANCE: ________________________ Plan Name:_________________________

Policy Holder: _____________________________ Date of Birth:____________ SS#________________

Policy Number: _____________________________Patient's Relationship to Policy Holder: ___________

Please make sure to provide any and all Secondary/Supplemental Insurances to the staff.

Patient is required to present a current insurance card and any updated information at each visit. Timely filing limitations for insurance companies are applicable. If I do not provide Complete Family Eyecare, Inc. with accurate insurance information and current insurance cards at the time of service, I will be responsible to pay for rendered services until information is updated. If a service is denied due to deductible, co-insurance, co-payment, or considers the services as non-covered, I accept total financial responsibility for any charges, attorney fees, and /or collection agency fees incurred in the process of recouping my payment. Copayment is due at the time of service. We required a deposit for all materials purchased.

*I have read, understand, and agree with the above information:

Signature:___________________________________ Date: _______________

OFFICE POLICIES

FEES:

Complete Family Eyecare (CFE) is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most up to date eyecare.

CONSENT TO TREAT:

I request and give consent to CFE to provide and perform such medical and vision eye care, tests, procedures, medications, and other services and supplies as are beneficial for my eye health, wellbeing and vision.

An Optomap Retinal Exam will be performed as one of the tests at your exam. The Optomap provides an eye wellness scan, gives an in-depth view of the retinal layers, provides an annual, permanent record for your medical file, is fast, easy, and comfortable and does NOT require dilation drops, which can result in blurred vision and sensitivity to light for 4-6 hours.

This test will help see early signs of any ocular conditions and systemic diseases such as:

- Age related Macular Degeneration
- Glaucoma
- High blood pressure
- Retinal holes or detachments

PAYMENT:

You are responsible for any co-pays, co-insurance, deductible and other non-covered services such as contact lens assessment and refraction at the time of service. If you are being seen for any ongoing medical condition, co-pays are due at each visit. If you are a self-pay patient and/or your insurance cannot be verified prior to your appointment, you will be required to pay in full the day services are rendered. All material orders must be paid for at the time of service before any orders are processed. No prescriptions will be released until professional services are paid for in full. Patients who receive a statement from our office are expected to remit full payment upon receipt. Statements will not be sent for any balance under $10.00. You may have a small balance on your account at the time of your next visit or order.

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections will be seen on an emergency only basis and must make payment in full prior to scheduling another appointment with our office.

Checks returned from your financial institution will be charged back to you with an additional $30 fee.

We offer 6 and 12 month payment plans through **Care Credit**.
You may apply for **Care Credit** at www.carecredit.com.

As required by the Health Insurance Portability and Accountability Act, Complete Family Eyecare may not use or disclose your health information without your authorization.

(Please Print)

I, ____, understand that this authorization is voluntary. I understand that my health information may be protected by the Federal rules for Privacy of Individually Identifiable Health Information and/or state laws. I understand my health information may be subject to re-disclosure for the purpose of billing insurance, referrals, prescriptions, and legal processes and if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.

I understand it is the policy of Complete Family Eyecare that all my appointments may be confirmed by phone or text prior to my office visit. If no one is home, a message will be left on my answering machine/voicemail with the time and date of my scheduled appointment. I understand this confirmation process cannot be waived or declined by myself or any individual.

I authorize Complete Family Eyecare may give information regarding my appointments and my healthcare information to the following person(s):

Name	Relationship	Birthdate	Phone Number
		/ /	
		/ /	
		/ /	

It is the patient's responsibility to add or remove any authorized person(s) to or from the above-listed names.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of my information/records for the purpose of billing to my insurance for my benefit management and claims administration, prescriptions, legal processes and subpoenas, mandated treatment referral, and/or the release of physical records as requested by myself or my legal representative.

I understand I do not have to sign this authorization form. I understand I may inspect or copy the protected health information to be disclosed by Complete Family Eyecare. I also understand, if, by my refusal to sign, I am preventing the billing of insurance for payment of charges, all non-emergent treatment may be refused.

Except to the extent when action has already been taken in confidence on this authorization, I may, at any time, revoke this authorization by submitting a written notice to the office of Complete Family Eyecare at any of the addresses listed below. Unless revoked, this authorization will not expire.

My signature below indicates I have been given an opportunity to ask any questions and have them answered before signing.

I authorize Complete Family Eyecare to release the protected health information as above.

Date ______________________________

Patient or Guardian Signature: ____

Relationship, if Guardian: ____

Office Policies (continued)

INSURANCE CLAIM FILING:

As a courtesy to our patients, we will file claims with insurance companies for which we are providers. We will do our best to verify benefits for services and/or materials; however, benefits quoted by your insurance carrier are not a guarantee of payment. You are responsible for supplying complete, accurate and up to date insurance information. Should your insurance deny a claim for any reason, you will be responsible for any remaining balances as directed by your insurance.

I would like CFE to file claims to my insurance on my behalf. My signature below authorizes CFE to act as my agent to bill for insurance and/or Medicare benefits, and I authorize payment of these benefits to be paid directly to CFE on my behalf. I authorize CFE to release any medical information needed to determine those payable benefits.

If CFE does not file claims to my insurance, I will be responsible for the total cost of all services provided.

PRESCRIPTION POLICIES:

Eyeglass lenses and frames may NOT be returned or exchanged after purchase. All lenses are made specifically for your vision needs and specifications. We will make any necessary adjustments to ensure proper fit and best vision possible.

If you choose to have your eyeglasses made outside of this office, we will NOT take any responsibility in the accuracy or quality of your eyeglasses. If you choose to have your eyeglasses made outside of this office, we recommend you reach an agreement with your eyeglasses dispenser before you place your order.

Contact lenses may only be returned for credit or exchange, no refunds will be given. They must be intact, in their original packaging with no markings, and returned within 30 days of receipt. Custom orders cannot be returned for credit. Fitting and assessment fees are non-refundable. Medical insurances do not cover the assessment for contact lenses. Wellness vision benefits such as VSP do not cover the fitting as part of their basic exam.

We do not take any responsibility for contact lenses purchased outside this office. If the prescription changes or the physical fit of the contact lenses change, you will be responsible for the cost of any new contact lenses.

I have read and agree to the above policies and conditions. Unless revoked by me in writing, this authorization will remain in effect for the lifetime of my relationship with Complete Family Eyecare.

Patient or Guardian Signature: ______________________________

For Guardian Signature, please indicate relationship to patient after your name. (*Jane Doe*, Mother)

FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE
PT INITIALS / ID ______
DATE ______

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc**. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 ○ 2 ○ 3 ● 4 ○ 5 ○

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Number of hours per day using a digital device: ______

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Dizziness

You experience dizziness, motion sickness, or vertigo.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
○	○	○	○	○

Additional notes: ______

Additional Notes

Any additional notes you'd like to add: ______

______