Welcome To Our Office! Date: Loc: Previous: Y/N

Welcome! Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient Name: _____ M / F
Address:_____City:_____State:_____Zip:_____
Phone:_____Home or Cell? Email:_____
Date of Birth:_____Age:_____Occupation:_____Employer:_____
Date of last exam:_____Were your eyes dilated?_____Hobbies:_____
Vision Insurance? Y/N Plan Name:_____ Member ID:_____Last 4 of SS#:____
Emergency Contact Name:_____Phone:_____Relation:_____
Medical Ins? Y/N Plan Name:_____Group:_____Ins number:_____
Name of Primary Card Holder:_____DOB:_____Relation:_____

I assign of all of my medical benefits to CLEAR VISION ASSOCIATES and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days-old are subject to collections, and there will be a service charge for any bounced checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time that they are rendered. There are no refunds on services.

Signature: X_____Date:_____

HIPAA Notice of Privacy Policies:
I acknowledge that I have read and/or received CLEAR VISION ASSOCIATES's Notice of Privacy Practices.

Signature: X_____Date:_____

Health-Related Communications & Reminders by Mobile Telephone Texting & E-Mail:
I permit CLEAR VISION ASSOCIATES to communicate & remind me about my health-related issues & appointments by texting & e-mail.

Signature: X_____Date:_____

Contact Lens Policy: In order to order CLs, you will need an active Rx. You may only receive an active Rx after a CL evaluation or CL re-evaluation. The purpose of a CL evaluation or re-evaluation is to check the health of your eyes and fit of your contact lenses with the most optimum prescription. This will need to done annually. It is an additional $75 to $95. No refunds will be given once the fitting is done. The fee for a CL evaluation includes the fitting of CLs and checkup care for up to 6 weeks. Failure to report any problems within this time frame will result in additional fees.
Want Contact Lenses? ◯Y /◯ N

Required Optomap Screening: The doctor requires an Optomap Screening at every exam (Cost is $39) to catch many diseases that can be treated. This may eliminate an eye dilation (prevents blurry eyes for 4-6hrs). Initials:_____

OVER THE AGE 50 OR HAVE DIABETES? (In addition to the optomap) O.C.T.: The doctor highly recommends an O.C.T. (Cost is $20) to catch many diseases that can be treated. An O.C.T. looks closely at the macula for degeneration or diabetes issues. May we perform the O.C.T.? ◯Y ◯N

PLEASE TURN PAGE OVER→

What is the main reason for today's eye exam?_____
When was your last eye exam?_____Where?:_____
Eye History: _____
Medical History:_____
_____
_____
Current Medications:_____
_____
Current Eye Drops:_____
Allergies:_____
Do you have Diabetes? Y/N What type?___How long?___years. Last blood sugar?_____HbA1c_____
Do you have High Blood Pressure? Y/N How long?____Last blood pressure reading:_____
Family History: High Blood Pressure: ◯ Macular degeneration: ◯ Diabetes: ◯
Retinal Detachment: ◯ Glaucoma: ◯ Cataracts: ◯ Explain any checks. Relation:_____
Personal Eye history: Have you had an eye operation? ◯ Type:_____Date:_____
Do you have glaucoma? ◯ Cataracts? ◯ Dry Eyes? ◯ Blurred vision? ◯
Do you see double? ◯ Do you have flashes of light? ◯ Do you see floaters? ◯
Do you have burning, itching, redness or tearing of your eyes? Explain:_____
Do you wear glasses? ◯ What kind? (Bifocal, Progressives, etc.)_____
Contact Lens History
Have you ever tried to wear contact lenses ◯Yes ◯No Do you currently wear contacts? ◯Yes ◯No Since:____
Type of contacts:_____Replace them how often?_____ days / weeks
What contact lens solutions do you use? _____
Please rate your current contact lenses on the following on a scale of 1 to 10 (1 worst, 10 best):
Lens Comfort: R_____L_____Distance Vision: R_____L_____Near Vision: R_____L_____
Social History:
Do you drink alcohol? ◯Yes ◯No How much? ◯Occasional ◯1 per week ◯1 per day ◯>2-3 per day
Do you smoke? ◯Yes ◯No If yes, how much?: ◯Occasional ◯½ pack a day ◯1 pack a day ◯1+pack a day
Hobbies / Interests:_____
Do you get headaches or pressure around your eyes, especially after reading or using screens? ◯Y ◯N
Do your eyes feel tired or strained by the end of the day? ◯Y ◯N
Do you experience neck or shoulder tension after computer work? ◯Y ◯N
Do symptoms improve when you rest your eyes? ◯Y ◯N
Do you lose your place or notice words blur or move while reading? ◯Y ◯N
Do busy environments like grocery stores make you feel visually overwhelmed or dizzy? ◯Y ◯N
Are your symptoms worse after long periods of screen time? ◯Y ◯N
Whom may we thank for referring you?_____

EYE HEALTH MANAGEMENT CONDITIONS (check all that apply)

SYSTEMIC CONDITIONS:	☐High Risk for Prediabetes	☐Diabetes	☐Hypertension	☐High Cholesterol
OCULAR CONDITIONS:	☐Diabetic Retinopathy	☐Glaucoma	☐AMD	☐None of these 7 conditions
☐Dilation Performed	☐PCP Communication Completed/Planned			

For Office Use ONLY:

__92004 / 92014
__92310 / 92310-21
__92015
__92250 **Primary ICD10:**_____
__92285
__92083
__92134 / 92133
Other CPT(s):_____

Filed Insurance? _____