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.

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 $55 to $75. 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

UNDER AGE 50? Optomap Screening: The doctor highly recommends Optomap Screenings (Cost is $39) to catch many diseases that can be treated. This may eliminate an eye dilation (prevents blurry eyes for 4-6hrs). May we perform the Optomap Screening? ◯Y ◯N

OVER AGE 50? Optomap Screening PLUS O.C.T.: The doctor highly recommends BOTH an Optomap Screening and O.C.T. (Cost is $59) to catch many diseases that can be treated. An OCT looks closely at the macula for degeneration. This may eliminate an eye dilation (prevents blurry eyes for 4-6hrs).
May we perform the Optomap Screening PLUS 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:_____

Referral Information

Whom may we thank for referring you?_____

For Office Use ONLY:

Filed Insurance? _____