

# WELCOME TO OUR OFFICE

## PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Street \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex: M F Work Phone \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email \_\_\_\_\_

**Would you like to receive communications by:**  
 text e-mail phone

Marital Status: Single Married Widowed Divorced

Soc Sec #: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

**What is the main reason for today's visit? Check one**

\_\_\_\_ Annual Routine Exam (no complaints)    \_\_\_\_ Contact Lenses  
 \_\_\_\_ Referral from another doctor    \_\_\_\_ Diabetes exam  
 \_\_\_\_ Specific problem with eyes or vision (describe below)  
 \_\_\_\_\_  
 \_\_\_\_\_

## INSURANCE INFORMATION

Vision Plan \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Soc Sec# \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Subscriber Birth date \_\_\_\_\_

**Medical insurance WILL cover eye examinations in many cases. Please enter your information below so we can determine your coverage.**

Medical Insurance \_\_\_\_\_

Subscribers Name \_\_\_\_\_

Subscriber Soc Sec# \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Subscriber Birth date \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Which pharmacy would you like prescription medications sent to: (Name and Location):  
 \_\_\_\_\_  
 \_\_\_\_\_

## PRIVACY PRACTICE ACKNOWLEDGEMENT

A copy of Treasure Coast Eye Associates' Notice of Privacy Practices is available on our website and at check in upon request. Please look over this document if you desire, and sign below that you have had an opportunity to review it. Copies are available if you would like a copy to take with you.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## NEW PATIENTS ONLY

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

**If not referred, how did you choose our office (check one and provide details)**

- Another Doctor \_\_\_\_\_
- Insurance List \_\_\_\_\_
- Website \_\_\_\_\_
- Newspaper/Radio/TV \_\_\_\_\_
- Other \_\_\_\_\_

## ASSIGNMENT AND RELEASE (Sign below to allow us to file your insurance)

Medicare and most medical insurances do NOT pay for routine vision examinations or refractions (to determine prescription for glasses). If refraction is necessary or requested during the exam, these insurances will disallow it, stating it is a non-covered service. Therefore, the patient will be responsible for the refraction charge. The refraction charge is **\$35**. If by chance your insurance does pay, we will refund that money to you.

The practice of waiving deductible and coinsurance amounts is illegal. I understand I am responsible for these payments.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the companies provided and assign directly to Treasure Coast Eye Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance, not Treasure Coast Eye Associates, and I am responsible for all charges whether or not paid by my insurance. If my insurance has not reimbursed this office in full within 90 days, I will be billed the outstanding balance. A 1.5% interest charge will be assessed monthly thereafter for past due balances. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of Insured/Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

(PLEASE FILL OUT OTHER SIDE ALSO)

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

## EYE HISTORY

<p>How long ago was Last Eye Examination? _____ By Whom? _____</p> <p>Do you wear glasses? YES NO All the time Occasionally Driving Only Reading Only Distance Only</p> <p><b>Contact Lens Wearers Only:</b> What kind/brand of contacts do you wear? _____ Cleaning solutions used: _____ How often do you replace your contacts? _____ How often do you sleep in your contacts? _____</p> <p>Are you satisfied with the vision and comfort of your current contact lenses? YES NO</p>	<p><b>Are you experiencing any of these symptoms since your last exam? (Please circle)</b></p> <p>Blurry Vision Red Eyes Burning Double Vision Discharge Flashes of Light Seeing spots Dry Eye Tearing Itching Light Sensitivity Night Vision Problems Temporary Loss of Vision Other _____</p>	<p><b>Have you ever been diagnosed or treated for any of the following? (Please circle)</b></p> <p>Glaucoma Cataracts Macular Degeneration Eye Injury Retinal Disease/Detachment Blindness Eye Turn/Strabismus Lazy Eye/Amblyopia Diabetic Eye Problems Dry Eye LASIK surgery Cataract surgery Diabetic eye laser treatment Glaucoma laser treatment Other _____</p>
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## MEDICAL HISTORY

Primary Care Physician \_\_\_\_\_  
Last Physical Exam \_\_\_\_\_

**Have you ever been diagnosed or treated for any of the following health problems? (Please circle)**

Anxiety	Kidney Disease
Allergies	Lupus/other autoimmune disease
Arthritis	Migraine headaches
Asthma/Emphysema/COPD	Muscle/Bone problems
Blood disorder	Pacemaker
Cancer	Rheumatoid arthritis
What kind? _____	Shingles
Depression	Skin condition
High Cholesterol	Stroke
Diabetes: Type 1 or Type 2	Other brain disease
How long diagnosed? _____	Psychological
Ears/Nose/Throat/Sinus	Thyroid
Heart condition	Pregnant
What type? _____	How many weeks? _____
High Blood Pressure	Other _____
HIV/AIDS	

## OTHER QUESTIONS

How many hours per day are you on a computer or digital device?  
\_\_\_\_\_ Hrs

How many hours per week do you spend outdoors?  
\_\_\_\_\_ Hrs

Smoking Status: (Please circle)  
Never Former Smoker Occasional Every Day

Alcohol Use: (Please circle)  
Never Socially Heavy

CURRENT MEDICATIONS (including eyedrops and over the counter)	MEDICATION ALLERGIES	FAMILY MEDICAL/EYE HISTORY	
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Does anyone in your family have any of the following conditions? Please circle and list the affected family members.</b></p> <p>Glaucoma _____</p> <p>Cataracts _____</p> <p>Macular Degeneration _____</p> <p>Retinal Disease _____</p> <p>Blindness _____</p> <p>Lazy Eye/Eye Turn _____</p> <p>Diabetes _____</p> <p>Cancer _____</p> <p>Heart Disease _____</p> <p>Other _____</p>	

# CONTACT LENS SERVICES

Contact lenses are Class II medical devices regulated by the FDA which require ongoing evaluation to ensure safe and comfortable wear. This service is separate and in addition to your comprehensive eye health and vision examination and includes:

- Contact lens insertion, care, and removal training
- Trial lenses to establish a good fit
- Evaluation of the fit of current or new lenses on the eye
- Evaluation of corneal, conjunctival, and eyelid health as related to contact lens wear
- Progress checks related to contact lens comfort and vision for 60 days following evaluation and/or fitting of lenses
- A contact lens prescription. The contact lens Rx will be dispensed to the patient once the fit is finalized by the doctor.

**Contact lens service fees are charged annually and the global fee includes a limited number of progress checks.**

Evaluation Fees are as follows:

<u>Type of evaluation</u>	<u>Cost</u>	<u># progress visits included</u>
Soft Spherical Single Vision	\$75.00	1
Soft Toric Single Vision and/or Monovision	\$90.00	2
Soft Multifocal	\$110.00	2
Rigid Gas Permeable Single Vision	\$110.00	2
Rigid Gas Permeable Toric/Bitoric or Monovision	\$125.00	2
Rigid Gas Permeable Multifocal	\$150.00	3
Specialty Contact Lens Fits	\$250.00+	unlimited for 60 days

**I have read the above and understand the following:**

\*\*These fees are for the contact lens evaluation ONLY and DO NOT include any supply of contact lenses. Some or all of these fees may be covered by a vision plan or medical insurance which we will file for you, but these fees are ultimately the patients responsibility.

\*\*The follow-up period for progress checks and finalizing a contact lens prescription is 60 days. Any follow-ups needed in addition to the included visits during those 60 days will be charged a \$25.00 per visit fee.

\*\*Every possible effort will be made to see that you are a good candidate for contact lens wear, however, situations arise that may preclude you from wearing lenses. There are NO REFUNDS on services.

Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION  
(PERMISSION TO SHARE):**

I give my permission for Treasure Coast Eye Associates to disclose my protected health information to the following individuals (i.e. family members, friends, etc.) until further notice:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ I decline to have mt records released to anyone

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ROUTINE VS MEDICAL EYE EXAM:**

- A **routine** eye examination is defined by insurance companies as an office visit for the purpose of checking vision, screening foe eye disease and updating eyeglasses and contact lens prescriptions.
- A **medical** eye examination is defined by insurance companies as an office visit for the purpose of assessing, diagnosing, and/or treating an eye problem.
- A **refraction** is a part of an eye exam that determine your prescription. This service has a fee of \$35 if it is not covered under the insurance provided.

If any medical eye complaints are addressed, pharmaceutical prescriptions are written, referrals for surgery or letters to other physicians are send, you visit will be billed to your medical insurance as is required by our insurance contracts.

**Please sign below that you have read and understand the statement above.**

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RETINAL HEALTH SCREENING TESTS:**

Treasure Coast Eye Associates takes pride in offering advanced eye care technology. The doctors recommend this test below at your annual eye examination. This test is NOT covered by insurance plans.

\_\_\_\_\_ **Digital Retinal Imaging      \$30**

Recommended for **NEW** or **ESTABLISHED** patients each year

Computerized imaging of the eye that allows instant viewing of the retina and optic nerve. These images are stored permanently and compared against any changes in the future.

\_\_\_\_\_ I decline this test

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_