MODERN EYE CARE
A MEMBER OF VISION SOURCE

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We are pleased to welcome you to our practice.
Please fill out this form as completely as possible.

PATIENT NAME _____ **SS#** _____-_____-_____

EMAIL _____ **DOB** _____/_____/_____

ADDRESS _____ **CITY**_____ **ZIP**_____

HOME (_____)_____-_____ **CELL** (_____)_____-_____ **WORK** (_____)_____-_____

ALLERGIES TO MEDICATIONS? _____

CURRENT MEDICATIONS: _____

_____

WHEN WAS YOUR LAST EYE EXAM? _____

WHEN DID YOU LAST UPDATE YOUR GLASSES? _____

CHECK ANY MEDICAL AND/OR EYE CONDITIONS THAT APPLY TO YOU

( ) Diabetes	( ) Seizures	( ) Thyroid Disease	( ) Kidney/Bladder
( ) High Blood Pressure	( ) Lung Disease	( ) Arthritis	( ) Psychiatric
( ) High Cholesterol	( ) Asthma	( ) Weight Loss/Gain	( ) Autoimmune
( ) Heart Disease	( ) Headache/Migraines	( ) Skin Eczema/Rash	( ) Stroke
( ) Vascular Disease	( ) Cancer	( ) Eye Surgery	
( ) Glaucoma	( ) Macular Degeneration	( ) Turned Eyes	( ) Other _____
( ) Cataracts	( ) Dry Eyes/Allergies	( ) Eye Injury	

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS

( ) Glaucoma	( ) Retinal Detachment	( ) Blindness	( ) Cancer
( ) Cataracts	( ) Turned/Crossed Eyes	( ) Diabetes	( ) Heart Disease
( ) Macular Degeneration	( ) Lazy Eye	( ) High Blood Pressure	( ) Thyroid Disease

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT?

( ) Distance blurred vision	( ) Dry/Burning eyes	( ) Eye Pain or Soreness	( ) One eye turns in or out
( ) Near blurred vision	( ) Eye Watering / Tearing	( ) Foreign matter in eyes	( ) Seeing flashes of light
( ) Sudden loss of vision	( ) Unusual Light Sensitivity	( ) Eyelids matted shut	( ) Floating spots in vision
( ) Frequent eyestrain	( ) Eye Itching / Allergies	( ) Mucous Discharge eyes	( ) Contact lens discomfort
( ) Frequent headaches	( ) Red eyes	( ) Double vision	

CONTACT LENS HISTORY and QUESTIONNAIRE (check all that apply):

( ) I am not interested in contacts today
( ) I have never worn contacts, but would like to discuss my options
( ) I have previously worn contacts, but since stopped, but would like to discuss my options
( ) I currently wear contact lenses; Brand/type: _____

Do you sleep in your lenses? YES NO **How often do you change your contacts?** _____

How old is your current pair of CONTACT lenses? _____

HIPAA CONTACT RELEASE FORM

In order to help us stay within the compliance guidelines of HIPAA, please list any person(s) below that you authorize for us to disclose information to regarding your protected health information, including billing information. (You do not need to list doctors)

1.) _____ Relationship_____
2.) _____ Relationship_____
3.) _____ Relationship_____

☐ **Information is NOT to be released to anyone**

Optomap Retinal Exam $45 copay

Our doctors order this crucial test as part of your comprehensive eye exam. This advanced technology allows instant viewing of the retina and optic nerve in great detail, which provides the doctors with the most ideal method to detect early signs of retinal disorders (including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment). By performing this test, the doctors will likely not need to dilate your eyes unless the test reveals undetected eye disease. It is particularly helpful when you return in future years as it provides a permanent record of your retina. Each subsequent year the OPTOMAP images can be compared to discover subtle changes and monitor your continuing eye health.

Signature: _____ Date: _____/_____/_____

Receipt of Notice of Privacy Policies & Consent Form

I acknowledge that I have been made aware of the location of the practice's Notice of Privacy Practices from Modern Eye Care. I have been given an opportunity to read this document, if I have so chosen to do so, and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company. I also understand that the premises are under video/audio/phone surveillance, and that these recordings will be kept strictly confidential. They may be used by Modern Eye Care in any way deemed necessary, including use by law enforcement and in a court of law. Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Modern Eye Care. If a medical diagnosis is found during your exam your medical insurance will be filled in lieu of your vision insurance plan. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. If insurance sends back any copays or coinsurance, or any amount towards patient deductibles it is the patient's responsibility to pay this balance within 90 days. Failure to do so will result in the balance being sent to a collections agency. Please sign below acknowledging that you understand: I, the undersigned, certify and assign to the doctor all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods. This authorization can only be rescinded by written notice.

Signature: _____ Date: _____/_____/_____