SOUTHCENTER EYE CARE

DR. MAI X. NGUYEN & DR. BENJAMIN D. CROWELL

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☐ Male ☐ Female

Name: _____ Preferred Name: _____

Address: _____ Date of Birth: _____

City: _____ State:_____ Zip:_____ SSN: _____

Email: _____ Occupation: _____

☐Home/☐Cell #: _____ Guardian: _____

Please provide your medical and vision insurance card(s) so we can make a copy

Vision insurance is applied if you are seen for a **wellness exam** and may include glasses and/or contact lens prescription.

Medical insurance is applied if you are seen for a **medical eye concern**. This includes and not limited to: care for diabetes, glaucoma, cataracts, retinal detachment, dry, itchy or red eyes. Medical insurance **DOES NOT** cover a refraction (prescription for glasses and/or contact lenses). **Copays and deductibles apply**.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act **(HIPPA)** is a federal law designated to protect the privacy of your health information. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process insurance claims, or mail/email exam recalls.

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and the final determination can only be made when the claim is processed. It is my responsibility to provide my insurance information to **SOUTHCENTER EYE CARE** for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of **$40** will be charged on any check returned for insufficient funds. Accounts 90 days or older will be submitted to a collection agency with a **30%** fee of the balance amount. I am aware exam fees are **NON-REFUNDABLE** after services have been provided.

GLASSES RECHECK POLICY

We will recheck any prescription at no cost **within 60 days** of the date of which the prescription was written. Rechecks will not be performed after 60 days from the original exam date and a new exam will be required, additional fees apply.

CONTACT LENS EVALUATION FEE

The Fairness to Contact Lens Consumers Act requires all contact lens wearers to have a contact lens examination to evaluate the health of the eyes and the fit of the contacts on the cornea. This service is *in addition* to your eye health exam and is typically not covered by vision plan benefits. The evaluation fee covers all follow-up visits for **60 days**. THIS FEE IS DUE AT THE TIME OF YOUR SERVICES AND IS **NON-REFUNDABLE**.

_____ **YES**, I would like a Contact Lens Prescription and accept the responsibility of the Contact Lens Evaluation fee.

_____ **NO**, I decline the Contact Lens Evaluation acknowledging that I will NOT be given a Contact Lens Prescription.

OPTOMAP® DIGITAL RETINAL IMAGING

The Optomap® Retinal Screening is a 200-degree retinal photo that gives the doctors a detailed view of your retina, the back part of your eye. It assists to detect and manage important ocular diseases such as glaucoma, diabetes, macular degeneration, retinal holes and detachments. Many eye and health conditions, if detected at an early stage, can be treated successfully without loss of vision. Your retinal image is stored electronically and gives the Doctor a permanent record of the condition of your eyes.

_____ **YES**, I would like to have a retinal photo performed today (**additional fee of $39**).

_____ **NO**, I would not like retinal photos at this time.

I have read and understand the Privacy Notice, Financial Agreement, Glasses Recheck, Contact Lens Evaluation Fee, and options for a Digital Retinal Imaging. By signing below I understand and agree to these terms and my responsibilities as a patient.

_____

Patient, Parent or Guardian Signature Date

→→ ***PLEASE COMPLETE THE BACK PAGE*** →→

MEDICAL HISTORY

Past Surgeries: _____

_____

Current Medication: _____

_____

_____

Allergies to Medication: ☐NO ☐YES If yes, explain: _____

_____

Pregnant or Nursing: ☐NO ☐YES If yes, how far along? _____

FAMILY HISTORY ☐ Adopted

*Please note any **family history** with the following conditions:*

	No	Mom	Dad	Sibling	Grandparent
Blindness	☐	☐	☐	☐	☐
Eye turn (Strabismus)	☐	☐	☐	☐	☐
Lazy Eye (Amblyopia)	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐
Retinal Detachment/Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

SOCIAL HISTORY

This information is required by insurance carrier and is kept strictly confidential.

Smoking history:

☐ Never ☐ Former ☐Some days ☐Every day

Alcohol use:

☐ None ☐ Occasional ☐ 1 drink/day ☐ 2+drinks/day

Illegal drugs:

☐ No ☐ Yes

REVIEW OF SYSTEM

*Do you **currently** have any problems with any of the following:*

CONSTITUTIONAL

Fever	No	Yes
Weight Gain/Loss	No	Yes

NEUROLOGICAL

Headaches	No	Yes
Migraine	No	Yes
Seizure	No	Yes
Multiple Sclerosis	No	Yes

EYES

Blurry vision w/ glasses	No	Yes
Sudden loss of vision	No	Yes
Double Vision	No	Yes
Flashes of light/Floaters	No	Yes
Red Eye	No	Yes
Eye Pain	No	Yes
Sandy/Gritty feeling	No	Yes
Itchy Eye	No	Yes
Dry Eye/Watery Eye	No	Yes

EAR / NOSE / THROAT

Allergies	No	Yes
Chronic Cough	No	Yes
Sinus Congestion	No	Yes

RESPIRATORY

Asthma	No	Yes
Bronchitis	No	Yes

VASCULAR / CARDIOVASCULAR

Heart Disease	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes
High Cholesterol	No	Yes

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	No	Yes
Muscle Pain	No	Yes
Joint Pain	No	Yes

ENDOCRINE

Thyroid	No	Yes
Diabetes	No	Yes

PSYCHIATRIC

Depression	No	Yes
Bipolar	No	Yes
Anxiety	No	Yes

GENITOURINARY

Genital/Kidney/Bladder	No	Yes

GASTROINTESINAL

IBS/Crohn's Disease	No	Yes

LYMPHATIC/HEMATOLOGIC

Anemia	No	Yes

If you answered **YES** to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____

_____

_____

_____