Epic Vision Eye Centers

Patient Health History

Date: _____

Name: _____ Date of Birth _____/_____/_____

Current Eye Care Provider(s) *and/or* Medical Doctor(s): _____

Eye Conditions		Eye Concerns	Vision Concerns	
☐ Cataracts	☐ Infections/Inflammation	☐ Redness	☐ Blurred Vision	☐ Poor Night Vision
☐ Macular Degeneration	☐ Allergies	☐ Burning	☐ Strain	☐ Bothersome Night Glare
☐ Glaucoma	☐ Flashes and/or Floaters	☐ Itching	☐ Pain	☐ Double Vision
☐ Diabetes	☐ Iritis/Uveitis	☐ Tearing	☐ Severe Sensitivity to Light	☐ Total Loss of Vision
☐ Diabetic Retinopathy	☐ Retinal Defects/Degeneration	☐ Discharge	☐ Headaches	
☐ Dry Eye	Other _____			

Do you wear eyeglasses? ☐ No ☐ Yes, how old _____ **Do you wear contact lenses?** ☐ No ☐ Yes, how old _____

What hobbies and/or recreational activities do you enjoy: _____

What corrective lenses are you mainly using for far/distant vision:	☐ None	☐ Eyeglasses	☐ Contacts	
Describe the quality of your far/distant vision:	☐ Acceptable	☐ Needs Improvement	☐ Blurred	
What corrective lenses are you mainly using for near/reading vision:	☐ None	☐ Eyeglasses	☐ Contacts	☐ Contacts w/ Glasses
Describe the quality of your near/reading vision:	☐ Acceptable	☐ Needs Improvement	☐ Blurred	
What corrective lenses are you mainly using for computer vision:	☐ None	☐ Eyeglasses	☐ Contacts	☐ Contacts w/ Glasses

Computer Demands	Performance Problems	Outdoor Demands	Eyeglasses Desires	Purchasing Plans
☐ Extended Use	☐ Poor/Low reading skills	☐ Extended Night Driving	☐ Replace broken/lost	☐ New full-time wear
☐ Unusual Ergonomic	☐ Inconsistent sports vision	☐ Outdoors in direct UV	☐ Extra pair for special activities	☐ Prescription sunglasses
☐ Multiple Monitors	☐ Slowness when shifting focus	☐ Reads in outdoor setting	☐ Thinner/Lighter Lenses	☐ New computer/reading
☐ Hours of use/day _____	☐ Issue w/ 3-D images/movies	☐ Irritated contact lenses	☐ Reduce Glare	☐ Supply of Contact Lenses

Review of Systems – Select the box if you currently or previously had problems in the following areas:

Constitutional
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome

Ear / Nose / Throat (ENT)
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Migraine
- ☐ Autism Spectrum Disorder

Psychiatric (PHYCH)
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bi – Polar Disorder

Cardiovascular
- ☐ Hypertension*
- ☐ Stroke / CVA*
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

Gastrointestinal (GI)
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Genitourinary (GU)
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD _____
- ☐ Benign Prostate Hypertrophy
- ☐ Currently Pregnant
- ☐ Currently Nursing

*Onset _____

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes - Simplex (cold sores)
- ☐ Herpes - Zoster (shingles)

*Medications? Y / N

Endocrine
- ☐ Diabetes - Type 2* / **
- ☐ Diabetes - Type 1* / **
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia

Allergy / Immunologic
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

**Diabetes - last blood sugar & A1C # + date taken _____

Medications – provide a detailed list or list any medication + dose: _____

_____

Allergies – Medication / Other / Latex? Y / N If yes, explain: _____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor.*

Do you drink alcohol and/or use tobacco products? Y / N If yes, type / amount / how long? _____

Family History – Has your relative (living/deceased) had these conditions? Relative = father (F), mother (M), brother (B), sister (S), son (S), daughter (D), grandparent (GP)

Ocular	Relationship	Systemic	Relationship	Systemic	Relationship
Glaucoma	F / M / B / S / S / D / GP	High Blood Pressure	F / M / B / S / S / D / GP	Cancer	F / M / B / S / S / D / GP
Macular Degeneration	F / M / B / S / S / D / GP	Diabetes 1 / 2	F / M / B / S / S / D / GP	Heart Disease	F / M / B / S / S / D / GP
Cataract	F / M / B / S / S / D / GP	Thyroid Disease	F / M / B / S / S / D / GP	Arthritis	F / M / B / S / S / D / GP

Patient Eye Surgical History – include type, date, eye, and Surgeon: _____

_____

Demographic Information

Epic Vision Eye Centers

PATIENT INFORMATION

□ Mr. □ Mrs. □ Ms. □ Dr. □ Prof Patient Name _____
(First) (Middle) (Last) (suffix)

Nickname _____ Date of Birth _____/_____/_____ Gender □ Male □ Female

Social Security # _____
*(**required for insurance submission**)*

Marital Status ☐ Single ☐ Married ☐ Other

Language ☐ English ☐ Spanish ☐ Other _____

Home Phone (_____) _____ - _____

Race ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Declined ☐ Hispanic ☐ Indian ☐ Native Hawaiian/Pacific Island ☐ Other _____

Work Phone (_____) _____ - _____

Ethnicity ☐ Asian ☐ Caucasian/White ☐ Declined ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native Hawaiian/Pacific Island ☐ Other _____

Cell Phone (_____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

Employment: ☐ Retired ☐ FT ☐ PT ☐ Homemaker ☐ Self ☐ Student Company Name _____

Email _____ Communication Opt-In Notifications: ☐ Text ☐ Phone ☐ Email

Family Members Names + Relationship _____

_____

GUARANTOR - FINANCIALLY RESPONSIBLE IF UNDER 18 AND/OR PRIMARY INSURANCE HOLDER IF DIFFERENT THAN ABOVE

□ Mr. □ Mrs. □ Ms. □ Dr. □ Prof Patient Name _____
(First) (Middle) (Last) (suffix)

Nickname _____ Date of Birth _____/_____/_____ Gender □ Male □ Female

Social Security # _____
*(**required for insurance submission**)*

Marital Status ☐ Single ☐ Married ☐ Other

Language ☐ English ☐ Spanish ☐ Other _____

Home Phone (_____) _____ - _____

Race ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Declined ☐ Hispanic ☐ Indian ☐ Native Hawaiian/Pacific Island ☐ Other _____

Work Phone (_____) _____ - _____

Ethnicity ☐ Asian ☐ Caucasian/White ☐ Declined ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native Hawaiian/Pacific Island ☐ Other _____

Cell Phone (_____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

Employment: ☐ Retired ☐ FT ☐ PT ☐ Homemaker ☐ Self ☐ Student Company Name _____

Email _____ Communication Opt-In Notifications: ☐ Text ☐ Phone ☐ Email

PRIMARY INSURANCE - *PRESENT INSURANCE CARD(S) TO FRONT DESK AT YOUR APPOINTMENT*

Policy Holder Name _____ Date of Birth _____/_____/_____
(First) (MI) (Last)

Name of Insurance _____ Phone of Insurance (_____) _____ - _____

ID # _____ Group # _____ Effective Date _____/_____/_____

SECONDARY / VISION INSURANCE - *PRESENT INSURANCE CARD(S) TO FRONT DESK AT YOUR APPOINTMENT*

Policy Holder Name _____ Date of Birth _____/_____/_____
(First) (MI) (Last)

Name of Insurance _____ Phone of Insurance (_____) _____ - _____

ID # _____ Group # _____ Effective Date _____/_____/_____

Epic Vision
Eye Centers

Patient Name_____ DOB_____

Financial Policy: To better serve our patients and keep costs to a minimum, our office maintains the following financial policy. Accepted forms of payment due at the time of service include cash, check ($35 returned check fee), credit card, flex spending card and/or care credit. As a courtesy Epic Vision will file your vision or medical claim on your behalf. You will be responsible for any balance that your insurance policy does not cover. Account balances must be resolved within 30 days of the mailing of your outstanding balance statement. Any account more than 90 days of receiving your outstanding balance statement may be referred to our collection agency and will include a 15% collection fee.

Privacy & Consent Policy: In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Epic Vision on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown and authorizes my doctor to act as my agent as above. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Epic Vision.

Signature on File: Signatures are required by patient/representative when Epic Vision will be billing the patients' insurances.

MEDICARE/ADVANTAGE: I request that payment of authorized Medicare benefits be made on my behalf to Epic Vision for services furnished to me by any Epic Vision Doctor. 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 or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Epic Vision accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

OTHER: I hereby authorize payment of my medical and surgical insurance benefits to Epic Vision. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Epic Vision. I authorize Epic Vision to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Signature_____ Date_____

A parent/legal representative signature is required for patients under the age of 18 years.