Patient Demographic Form

(Please Print)

Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Sex: M/F Date of Birth: _____ Age: _____ Social Security: _____ - _____ - _____

Ethnicity/Race/Language: _____

Mailing Address: _____ City/State/Zip Code: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Email Address: _____

Occupation: _____ Employer: _____

Marital Status: Single/Widow/Married

Spouse's Name: _____ Date of Birth: _____

Insurance/Billing Information

Do you have vision insurance: Y/N

Insurance name: _____ Identification Number: _____

Insured/Policy Holder's Name: _____ Date Of Birth: _____

Relation to patient: _____ Insured Social Security: _____

Do you have medical insurance: Y/N

Insurance Name: _____ Identification Number: _____

Insured/Policy Holder's Name: _____ Date of Birth: _____

Relation to patient: _____ Insured Social Security: _____

Assignment and Release

I have acknowledged that I, and/or my dependents have insurance coverage and assign directly to Dr. Amy Henry/Victoria Family Eyecare, PLLC, all insurance benefits if any payable for services rendered. I understand that I am financially responsible for all charges not covered by my insurance including all applicable copays and deductibles. I authorize the use of my signature in all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above listed insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Printed Name: _____ Relation to patient: _____

Signature: _____ Date: _____

Medical History

(Please Print)

Reason for today's visit, please check all that apply:

__Routine Eye Exam
__Contact Lens Exam
__Diabetic Eye Exam
__Cataracts
__Dry Eyes
__Red Eyes
__Sudden Vision Loss
__Headaches
__Double Vision
__Floaters/Flashes
__Light Sensitivity
__Computer Related Eye Discomfort
__Burning/Tearing Eyes
__Allergies/Itchy Eyes

Do you wear glasses? Y/N **If yes, how often? Full time/Reading/Driving/While using computer**

Do you currently wear contact lenses? Y/N **Brand:** _____ **Hours/Days:** _____

List any medications, vitamins, etc. that you are presently taking: _____

_____

List any medication allergies: _____

Do you use tobacco products? Y/N **Do you drink alcohol? Y/N** **Are you pregnant? Y/N**

Height: _____ **Weight:** _____ **Primary Care Physician:** _____

Have you are a family member had any of the following:

	You	Family		You	Family		You	Family
AIDS/HIV	Y/N		Allergy Shots	Y/N	Y/N _____	High Cholesterol	Y/N	Y/N _____
Diabetes	Y/N	Y/N _____	Lupus	Y/N	Y/N _____	Asthma	Y/N	Y/N _____
Epilepsy	Y/N	Y/N _____	Thyroid Conditions	Y/N	Y/N _____	Pacemaker	Y/N	Y/N _____
Hepatitis	Y/N	Y/N _____	Multiple Sclerosis	Y/N	Y/N _____	Blood/Lymph Disorder	Y/N	Y/N _____
Kidney Disease	Y/N	Y/N _____	Alcoholism	Y/N	Y/N _____	Rheumatoid Arthritis	Y/N	Y/N _____
Liver Disease	Y/N	Y/N _____	Emphysema	Y/N	Y/N _____	Cancer	Y/N	Y/N _____
Osteoarthritis	Y/N	Y/N _____	Heart Disease	Y/N	Y/N _____	Shingles	Y/N	Y/N _____
Stroke	Y/N	Y/N _____	High Blood Pressure	Y/N	Y/N _____	Herpes	Y/N	Y/N _____
Glaucoma	Y/N	Y/N _____	Macular Degeneration	Y/N	Y/N _____	Migraine Headaches	Y/N	Y/N _____
Retinal Disease	Y/N	Y/N _____	Lazy Eye	Y/N	Y/N _____			
Cataract Surgery	Y/N	Year : _____	RK Surgery	Y/N	Year: _____	Lasik Surgery	Y/N	Year: _____

Office Policies

Routine Exam vs Medical Office Visit

Routine eye exams as commonly defined for insurance purpose specifically does not include detection and/or diagnosis of underlying "medical" conditions.

Should your exam present a "medical diagnosis" and/or a pharmaceutical prescription is written, such diagnosis requires that we base our fees, and insurance filings as such per Victoria Family Eyecare's policy. Medical copays and deductibles will apply. A disclosure to your medical insurance carrier is required. Our staff will inform you of this at time of discharge and any applicable fees will be collected.

Signature: _____ Date: _____

Refraction Policy

1. What is a refraction? A refraction determines your need for corrective lenses (glasses). However, it can also detect vision loss. Sometimes this loss can be slow, progressive, and go unnoticed by the patient. This test can reveal other conditions that the patient may not detect.

2. Why doesn't my insurance cover the refraction? Health insurance companies including Medicare, consider the refraction to be vision care and unrelated to the medical reason for your visit. The separate fee for your service might be covered by your vision insurance plan. You will be provided a receipt for the refraction which you may choose to file with your vision plan.

3. Do I have to pay for the refraction? Yes. The Office of the Inspector General has deemed that not charging for a provided service is an "inducement" to the patient and therefore illegal. All services performed must be billed in order to insure that doctors are not offering incentives to patients for their patronage.

4. Do I have to have the refraction done? No. If you opt not to have the refraction done, please make the optometrist aware. Please note that not having the refraction performed, a prescription for glasses WILL NOT be provided since the refraction determines your need for corrective lenses. Please initial here if you DO NOT want the refraction. Initial: _____ Date: _____

Acknowledgement

I have read the above information regarding the refraction and understand that I am fully responsible for the $45 fee for the refraction if not covered by my insurance. I agree to pay this fee at time of service plus any applicable copays and deductibles at the time of service.

Signature: _____ Date: _____

HIPAA Privacy Policy

I, _____, have read and understand the Notice of Privacy Practices. I do/do not (please circle one) wish to receive a copy of this.

I understand that Victoria Family Eyecare, PLLC, or any of its employees will not discuss any financial or medical information regarding myself with anyone unless they are listed.

I give Victoria Family Eyecare, PLLC, permission to speak with the following people regarding my financial responsibility and/or medical information:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Signature: _____ Date: _____