EYE
PHYSICIANS & SURGEONS

Patient Information

DATE_____

Name_____DOB_____Sex___
Phone Home_____Work_____Cell_____
SSN_____ Email Address_____
Address_____City/State_____Zip Code_____
Do you live in a skilled nursing facility? Y N Employer_____
Marital Status_____Guardian/Parent (Name/Number)_____
Primary Care Provider_____Referring Provider_____
Emergency Contact (Name/Phone Number)_____
Primary Insurance Company_____
ID#_____Group#_____Subscriber Name/DOB_____
Secondary Insurance Company_____
ID#_____Group#_____Subscriber Name/DOB_____

Patient Health History

Please list your current medications:_____
_____
_____
Do you have any allergies to any medications? Y N
If yes, please list the medication(s) and type of reaction(s)_____
Do you have an allergy to latex? Y N
Do you have an allergy to adhesive or tape? Y N
Do you wear glasses? Y N
Do you use tobacco? Y N Current Past Never
Please list any recent surgeries or hospitalizations including dates and reasons:_____
_____

Please indicate if you have the following:

Glaucoma Y N	Eye Injury/Surgery Y N	Amblyopia Y N	Cataract Y N
Macular Degeneration Y N	Strabismus Y N	Dry Eye Y N	Hypertension Y N
Stroke Y N	High Cholesterol Y N	Anxiety/Depression Y N	Cancer and type Y N
Heart Disease Y N	Thyroid Disease Y N	Arthritis and type Y N	Diabetes Y N
Allergies Y N	Flu Shot/Year Y N	Pneumonia Shot/Year Y N	Other:

Please indicate if you have a family history of the following:

Diabetes Y N	Glaucoma Y N	Mac Degeneration Y N	Heart Disease Y N
Amblyopia Y N	Cancer Y N	High Cholesterol Y N	Thyroid Disease Y N
Strabismus Y N	Hypertension Y N	Other:	

FINANCIAL POLICY & CONSENT

Thank you for choosing Eye Physicians & Surgeons as your health care provider. We are committed to building a successful relationship with you and your family. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. You are asked to sign this acknowledgment stating you have read and agreed to our Financial Policy prior to services being rendered.

Insurance Claims

Please bring your insurance cards to every visit. In order to properly bill your insurance company, we require that you provide accurate and current insurance information including primary and secondary insurance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. By signing this form, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. **It is your responsibility to check with your insurance company to be sure we participate with your plan.** If we do not participate in your plan, you will be responsible for full payment.

*****PLEASE NOTE THAT ONLY DRS. BOWEN, FISHILEVICH, PATEL AND THE OPTICAL SHOP FOR MATERIALS (EYEGLASSES AND CONTACT LENSES) PARTICIPATE WITH EYEMED.*****

Routine vs Medical Exam

A Routine Vision Exam is a screening exam which is performed as a "healthy" visit. It is most frequently requested by patients to determine the need for corrective lenses. Not all insurances cover screening exams or offer a "vision" benefit. It is your responsibility to know if you have this benefit and how often it may be available. You will be responsible for payment if your vision exam is not covered. A Medical Exam is billed to your medical insurance with the symptom or condition which was examined on the day of the visit.

Refraction

Refraction is the process of determining the eye's need for glasses or contact lenses. This is often done by checking your ability to see an eye chart using corrective lenses. Refraction also provides us with important information about the function of your eyes and may alert us to any problems that are related to a decrease in visual acuity. Our refraction fee is $60.00 and generally not covered by insurance, including Medicare. It is billed to the patient in addition to the exam charge and is payable at the time of service.

Agreement

By signing this statement, I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment, and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not covered by my insurance company. I also understand that verification of my benefits is not a guarantee of payment. I understand that my signature requests that payment be made and authorize the release of my medical information necessary to pay the claim. In addition, I understand that I will be charged a $50.00 fee for any no-show appointments that I incur, and I will be charged 12% of my total visit bill after two statements for non-payment of monies that were directly my responsibility. I also agree to receive email communications from the office regarding my appointment and/or bill as applicable. I understand I can opt out of receiving emails at any time by informing this office.

Signature of Patient and/or Guardian_____Date_____

Please visit our website to make payments, submit inquiries, and request appointments at www.eyedocsct.com.