Mrs. Ms. Mr. Dr. _____ Date of Birth:_____ Age:_____
(First Middle Initial Last)

Address:_____City, State, Zip_____

Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander | Other_____Gender:Male | Female

Status: Minor | Single | Married | Divorced | Widow | Separated Prefered Pharmacy:_____

Home Number:_____Work Number:_____

Cell Phone Number:_____SS Number:_____

E-mail Address:_____Occupation:_____Employer/School_____

Spouse/Parents Name:_____Employer:_____Work Number:_____

Who is your emergency contact?_____Relation:_____Phone:_____

Date of Last Physical:_____Family Doctor:_____

Date of Last Eye Exam:_____Location of Last Eye Exam:_____

Type of Exam You Are Here For: ☐ Contact Lenses ☐ Spectacles ☐ Both ☐ Other _____

## Personal Eye Information

| | | | |
|---|---|---|---|
| Do you wear glasses? | Y N | Do you wear contact lenses? | Y N |
| Do you ever see double? | Y N | Do you get frequent headaches? | Y N |
| Do you have glaucoma? | Y N | Do you have cataracts? | Y N |
| Do you have macular degeneration? | Y N | Do you ever see flashes or floaters? | Y N |
| Have you ever been told you have amblyopia, "lazy eye"? | Y N | Are you interested in wearing contact lenses? | Y N |

Have you ever had any eye injuries or surgeries? Y N If yes, please list:_____

Are there any problems with your current glasses/contact Lenses?_____

## Medical Information

Have you ever been diagnosed or treated for:

| | | | | | |
|---|---|---|---|---|---|
| Neurological Disorder/Type:_____ | Y N | Breathing Problems/Type:_____ | Y N | Cancer/Type:_____ | Y N |
| High Blood Pressure: | Y N | Thyroid Disease: | Y N | Heart Disease:_____ | Y N |
| High Cholesterol: | Y N | Suffered from a stroke: | Y N | Arthritis: | Y N |
| Seasonal Allergies: | Y N | Depression/Anxiety:_____ | Y N | Frequent Headaches: | Y N |

Are you Diabetic: Y N, If yes, what type?: _____

Drug Allergies: Y N, If yes, please list:_____

List any medications taken (including eye drops and vitamins)

_____

_____

Please list any other health condition that you have not listed above (including if you are pregnant or nursing) and any surgeries you have had: _____

_____

Check the box that best describes your tobacco use:

☐ None ☐ Former Smoker ☐ Light Smoker < 1 pack/day ☐ Average Smoker 1-2 packs/day ☐ Heavy > 2 packs/day

☐ Smokeless Tobacco ☐ How many years/months?_____

Check the box that best describes your alcohol use:

☐ None ☐ Social Use Only ☐ 1-2 Drinks Daily ☐ Above Average Use ☐ Alcohol Dependent

## Family History

Does anyone in your family have?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Glaucoma | Y N | Turned or Lazy Eye | Y N | Cataract | Y N | Blindness | Y N |
| Macular Degeneration | Y N | Heart Disease | Y N | Diabetes | Y N | High Blood Pressure | Y N |

## Lake Erie Family Eyecare Insurance and Payment Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to track the individual requirements of each plan. If we are not informed of any special requirements in your contract on the date of service, and the charges are not covered, you will be responsible for those charges. Please note the following is required:

- **Proof of Insurance: We ask that you present your insurance card to us at every visit. If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.**
- **We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service. If you are insured by a plan we are contracted with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.**
- **Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.**
- **Non-covered Service: Please be aware that some or all of the services you receive may be non-covered or not considered necessary by your insurer. You must pay for these services in full.**
- **Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.**

## Acknowledgment of Notice of Lake Erie Family Eyecare Insurance and Payment Policy:

Print name of responsible party:_____

Signature of responsible party:_____Date:_____

## HIPAA Privacy Policy

I certify that I have read and understand the above information to the best of my knowledge, and that I have answered the attached questions accurately. I authorize Lake Erie Family Eyecare to release any information including diagnosis and the records of any treatment or examination rendered to me or to my child to third party providers and/or other health care practitioners. I am aware that my eyecare/medical insurance carrier may pay less than the actual bill for services. I agree that I am responsible for payment of all services rendered on my behalf of my dependents. I understand this policy will stay in effect unless the responsible party asks for it to be revoked in writing.

## HIPAA Privacy Acknowledgment of Receipt of Notice of Privacy Practices:

I,_____(Please print full legal name here), have been presented with the Notice of Privacy Policy (HIPPA Privacy Policy) of Lake Erie Family Eyecare, and have been offered a copy of such policy to keep for my records if desired.
Signature:_____Date:_____

**Do we have permission to share your medical information with family? (Please circle one)**

**Yes No If yes, please list names, relation, and contact information below.**

Name:_____Relation:_____ Contact Number:_____

Name:_____Relation:_____ Contact Number:_____

## Insurance Information

Name of Vision Insurance:_____

Policyholder Name:_____Date of Birth:_____