Eyecare Examination Form

Patient's Name: _____ Preferred name: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Work phone: _____

Date of Birth: _____ Social Security #: _____

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

Marital Status: ☐ Married ☐ Single Sex: ☐ Male ☐ Female
☐ Widow/Widower ☐ Divorced

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name if applicable: _____ Date of Birth: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

How were you referred to our office?

☐ Physician/Optometrist ☐ Radio ☐ Friend ☐ Yellow Pages
☐ RSVP Mailer ☐ Family ☐ Self ☐ Other
☐ Vision Screening ☐ Sports Program ☐ Church Bulletin

What Pharmacy do you use? _____ Address: _____

Last Exam/Eye Dr. _____

Primary Care Physician _____ Referring Physician _____

Address: _____ Address: _____

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

Phone Number: _____ Phone Number: _____

Current medications (including eye drops):_____

_____

Past Ocular History

Have you ever been diagnosed with any eye disease? _____

Have you ever had any accidents or eye surgery (including laser surgery)? _____

Is there any family history of eye disease? _____

Past Medical History: Please check ALL that apply.

Cancer:

- o Breast Cancer
- o Colon Cancer
- o Lung Cancer
- o Prostate Cancer
- o Radiation
- o Other _____

Cardiovascular:

- o Atrial Fibrilation
- o Cholesterol
- o Heart disease
- o Hypertension
- o Other _____

Endocrine:

- o Diabetes
- o Thyroid disease
- o Other _____

Gastrointestinal:

- o Acid Reflux
- o Crohn's disease
- o Colitis
- o Ulcer
- o Hepatitis
- o Other _____

Genitourinary:

- o Benign Prostatic Hypertrophy
- o End Stage Renal Disease
- o Other _____

Hematologic/Lymphatic:

- o Anemia
- o Bone Marrow Transplantation
- o Leukemia
- o Lymphoma
- o Other_____

Musculoskeletal:

- o Arthritis
- o Ankylosing Spondylitis
- o Lupus
- o Other _____

Neurological:

- o Epilepsy
- o Hearing Loss
- o Multiple Sclerosis
- o Stroke
- o Other _____

Psychiatric:

- o Anxiety
- o Depression
- o Other _____

Respiratory:

- o Asthma
- o COPD
- o Sarcoidosis
- o Other _____

Skin:

- o Eczema
- o Rosacea
- o Psoriasis
- o Other_____

Soc Hx:

- o Smoke
- o Drink
- o Take recreational drugs

Medication Allergies:

- o Yes
- o No

If yes,
list:_____
_____

Review of Systems: Do you have, or have you ever had any of the following conditions/systems?
Please check ALL that apply.

- o Change in vision
- o Blurry vision
- o Redness
- o Double vision
- o Dry eyes
- o Baggy eyelids
- o Tearing
- o Eye pain/soreness
- o Retinal disease
- o Glaucoma
- o Eye injury
- o Do you wear glasses?
- o Distance glasses
- o Reading glasses?
- o Bifocals?
- o Do you wear contacts?
- o If you wear glasses/contacts you have any desire to get out of glasses/contact lenses
- o Dry mouth
- o Difficulty hearing/ringing in ears
- o Chronic cough
- o Asthma/wheezing
- o Shortness of breath when lying flat on your back
- o COPD/shortness of breath
- o Jaw pain
- o Weight loss
- o Scalp tenderness
- o Fever
- o Joint pain/swelling
- o Indigestion
- o Frequent or severe vomiting
- o Frequent diarrhea
- o Rash
- o Rosacea
- o Unusual moles
- o Skin cancer
- o Headaches
- o Fainting spells
- o History of a stroke/TIA
- o Seizures
- o High blood pressure
- o Chest pain/discomfort
- o Palpitations/Arrhythmia
- o Shortness of breath with exertion
- o Cardiac stents/MI
- o CHF
- o Irregular heart beat
- o Easily bruise
- o Anemia
- o Blood disorder/clot
- o Enlarged lymph nodes
- o Anxiety
- o Depression
- o Panic attacks
- o Bipolar disorder
- o Problems sleeping/Insomnia
- o Diabetes
- o Thyroid abnormalities
- o Insulin dependent
- o Frequent urination
- o Incontinence
- o Prostate/BPH
- o Flomax
- o Hepatitis A,B,C
- o HIV
- o Lupus
- o Environmental allergies
- o Hay fever/Allergies
- o Rheumatoid arthritis
- o Fibromyalgia
- o **Pregnant**
- o **Complications with anesthesia**
- o **Do you have defibrillator?**
- o **Do you have a pacemaker?**
- o **Are you on blood thinners**

Patient Privacy instructions

I hereby acknowledge that I have been provided an opportunity to receive a copy of the Notice of Privacy practices for Worthington Ophthalmology.

I have ☐ **Received** ☐ **Declined** the Privacy Notice and, I understand my rights as a patient with regard to privacy of health care information.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Worthington Ophthalmology has permission to contact me on my cell phone? YES/NO

Worthington Ophthalmology has permission to leave messages on my home or cell phone? YES/NO

Patient Signature (or Guardian):_____

Date_____

Financial Agreement 1/1/2020

Thank you for allowing us to participate in your eye care. If you have medical insurance, we are committed to helping you receive your maximum allowed benefits. We understand the medical insurance can be quite confusing. Our financial policy is provided to assist you in understanding your responsibility to both Worthington Ophthalmology and your insurance carrier.

Medicaid/Medicare: we are providers with Medicaid and Medicare. We agreed to Bill and accept contractual adjustments for both programs. You are responsible for all deductibles and co-pays. Supplemental insurance: if you have supplemental insurance, we will send a claim to them as a courtesy to you.

Insurance: your insurance policy is a contract between you and the insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend our patients, all charges are your responsibility from the date that services are rendered. You are expected to know and follow all regulations or procedures as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. Any out-of-pocket expenses such as deductibles, coinsurance and co-pays must be paid at the time of service. We will be happy to provide you with an exam, surgical, or procedure codes prior to your visit or procedure, so you may contact your insurance provider to better understand your potential out-of-pocket costs. Pre-dictated exam and procedure codes are subject to change depending on the doctor's determination of necessity. Failure to provide correct information (current insurance carrier, policy number, etc.) May result in denial of your claim, you will be held responsible for the balance. If you belong to HMO (needing a referral from your primary care physician) we cannot see you without a referral unless you pay for your visit yourself.

Co-pays: in accordance with your insurance contract, your co-pay is due at the time of service.

Self-pay patients: self-pay patients will be billed at 110% of the Medicare allowable rate. Payment in full is due at the time of your service.

Methods of payment: we accept cash, check, Visa, MasterCard and methods of payment: we accept cash, check, Visa, MasterCard and Discover.

Returned checks: any check that does not clear your bank account results in a $25 fee.

Refunds: if an over payment has been made, a refund check will be issued to you. Refunds for 10.01 or greater are processed monthly. Over payments for $10 or less will be credited to your next visit if you don't want your account credited, contact the billing department and your refund will be issued.

Statements/Credit Card Policy: If there is a balance on your account after filing to your insurance carrier, you will receive a statement. A credit card will be held on file as per our credit card on file policy, if your account is not paid in 30 days from receiving your statement, we will process the credit card on file. If you have any questions regarding your statement, please contact the billing department immediately. If you are unable to pay your balance please contact our office to establish a payment plan. We reserve the right to impose 10% finance charge on accounts not paid within 30 days.

I have read and understand the financial policy of Worthington Ophthalmology, Inc. Regarding payments and insurance. **I consent to leaving a credit card on file and having this card charged for unpaid balances over 30 days**. I also understand that I am responsible for following my insurance plan regulations, policies and procedures._____.

Patient Signature/ Guarantor's Signature and Date (Updated 1/1/2019)