WELCOME TO OUR OFFICE!

Thank you for allowing us to provide for your eye care needs. Please complete the following information to allow us to better serve you.

Full Name:____ Nickname: ___________________
Address:____ Date of Birth: __________________
City, State, ZIP: ____ Occupation: __________________
Social Security Number: _________________________ Work Phone: ______________________________
Home Phone: _________________________________ Cell Phone: _______________________________
Email: ____
May we contact you by email? yes □ no □ Preferred contact method? Work Home Cell Email
Referred by: Family Friend Doctor YellowScene Walk-in Website: ________________________
If personally referred, whom may we thank for the referral? ____
Reason for today's visit: ____

Medical Insurance (for medical visits, e.g. red eyes, infections, trauma):
Company: _______________________ Primary Insured Name: _________________________________
Vision Insurance (for routine exams):
Company: _______________________ Primary Insured Name: _________________________________

Eye History
Do you wear glasses? yes □ no □ If yes, how old are your current pair of lenses? _______________________
Do you wear contact lenses? yes □ no □ If yes, how old are your current pair of lenses? _______________________
Type of lenses? soft □ extended wear □ gas permeable □ Are they comfortable? yes □ no □

Medical History
Are you allergic to any medications? yes □ no □ If yes, please list: ____
____
List any medications you take (including aspirin, over the counter medications, home remedies, and oral contraceptives)
____
____
____
Are you pregnant or nursing? yes □ no □
Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following

CONDITION/DISEASE	No	Yourself	Relative	CONDITION/DISEASE	No	Yourself	Relative
Blindness	□	□	□	Diabetes	□	□	□
Cataract	□	□	□	Heart Disease	□	□	□
Crossed Eyes	□	□	□	High Blood Pressure	□	□	□
Glaucoma	□	□	□	Kidney Disease	□	□	□
Macular Degeneration	□	□	□	Thyroid Disease	□	□	□
Retinal Detachment	□	□	□	Cancer	□	□	□
Arthritis	□	□	□	Other____________	□	□	□

Social History *This information is kept strictly confidential. However, you may discuss this directly with the doctor.*
□ Yes, I prefer to discuss my Social History directly with the doctor

Do you drive? □ Yes □ No Do you have difficulties when driving? □ Yes □ No If yes, please describe: ____________
____
Do you use tobacco products? □ Yes □ No If yes, type/amount/how long? ______________________________
Do you drink alcohol? □ Yes □ No If yes, type/amount/how long? ______________________________
Do you use illegal drugs? □ Yes □ No If yes, type/amount/how long? ______________________________
Have you ever been exposed to or infected with: □ Gonorrhea □ Syphilis □ HIV □ Hepatitis

Review of Systems

Do you currently or have you ever had any problems in the following areas:

SYSTEM	No	Yes
CONSTITUTIONAL		
fever, weight loss/gain	☐	☐
INTEGUMENTARY (skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Surgery	☐	☐
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Chronic Infection of Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

SYSTEM	No	Yes
EAR, NOSE, THROAT, MOUTH		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

ACKOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been **offered** a copy of **Erie Family Eyecare Notice of Privacy Practices** to review today and a take home copy.

Patient name (please print) ____ Date: _________________

Signature (patient or guardian) ____

Patient Financial Agreement

Thank you for choosing Erie Family Eyecare. Our primary mission is to deliver the finest and most comprehensive vision care available.

The funds necessary for your eye care treatment are an estimate based on information determined from our initial examination. The cost of your estimate may increase if the Doctor determines that a more in-depth exam is needed or additional problems are observed.

FOR PATIENTS WITH CLAIMS THAT WILL BE BILLED TO THEIR MEDICAL OR VISION INSURANCE PLAN: Your insurance is a contract between you and your insurance company, not between Erie Family Eyecare and the insurance company. Acceptance of insurance assignment by this office does not absolve you of your responsibility for the charges for the treatment rendered. An estimate will be given to you at the end of your office visit to be used as a guideline until the final insurance payment is received, and your account has been reconciled. We can make no guarantees of the insurance payment. If your insurance does not pay for a procedure or informs us that your co-payment is more than what we had initially charged at the time of your visit, you are responsible for payment in full. If there are any discrepancies please contact your insurance company and/or employers benefit department.

Patients are ultimately responsible for any charges incurred in the office.

Accounts outstanding ninety days or more may be subject to an 18% annual interest charge.

In the event that your balance is sent to the collection agency, you are responsible for full payment of your account and any collection fees incurred.

Erie Family Eyecare charges $25.00 for returned checks.

A fee of $25.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 24 hour notice.

I understand and agree to take full responsibility as outlined in this financial agreement for the patient listed below.   Any termination of this agreement may only be done in writing and will not apply to any action in process.

____   ____________

Patient Name   (please print)   Date

____

Signature (patient or guardian)

REGARDING VISION PLANS & MEDICAL INSURANCE

We often have patients that have both vision insurance (for example, VSP or EyeMed) and medical insurance (for example, Blue Cross, Aetna, Blue Shield, or Medicare). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and/or treatments. Medical insurance is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurance.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your medical insurance, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules. They are made by the insurance companies themselves and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance. I authorize Erie Family Eyecare to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signature: ____ Date: ______________________

Printed name:____

Patient’s name (if different from above): ____