

Date: \_\_\_\_\_

General History

Name: \_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

How you were referred to us? \_\_\_\_\_ Hobbies: \_\_\_\_\_

Date past eye exam: \_\_\_\_\_ Name of previous eye doctor: \_\_\_\_\_

Number of hours spent on a computer per day: \_\_\_\_\_

Check if you have any of the following:

- Blurred Vision
- Glare from lights at night
- Sensitivity to sunlight
- Floaters
- Headaches, if yes, How often? \_\_\_\_\_ Location: \_\_\_\_\_ Duration: \_\_\_\_\_
- Do You: Smoke?  Yes  No If yes, how many cigarettes per day? \_\_\_\_\_
- Drink?  Yes  No If yes, how many drinks per day? \_\_\_\_\_
- Wear Contacts?  Yes  No Are you interested in Contacts?  Yes  No  Colored
- If yes, What type/brand do you wear? \_\_\_\_\_ Hrs.worn per day: \_\_\_\_\_
- When did you last wear contacts? \_\_\_\_\_ How old are they? \_\_\_\_\_
- Want to change your eye color with contacts?  Yes  No Are you considering laser refractive surgery?  Yes  No

Ocular History

Date of your last medical exam: \_\_\_\_\_ Name of physician: \_\_\_\_\_

List all of the following conditions you have, the YEAR it was FIRST DIAGNOSED, and ALL MEDICATIONS you're taking for each:

- Yes No Surgeries/Operations: \_\_\_\_\_
- Yes No Allergies to Medications and other allergies: \_\_\_\_\_
- Yes No Immune System (HIV, Lupus, MS, etc.): \_\_\_\_\_
- Yes No Sinus: \_\_\_\_\_
- Yes No Respiratory (Lungs, T.B., etc.): \_\_\_\_\_
- Yes No Cardiovascular (Heart, High Blood Pressure, etc.): \_\_\_\_\_
- Yes No High Cholesterol: \_\_\_\_\_
- Yes No Stomach, Colon: \_\_\_\_\_
- Yes No Neurological (Seizures, Paralysis, etc.): \_\_\_\_\_
- Yes No Arthritis, Bones, Joints, Muscles: \_\_\_\_\_
- Yes No Hepatitis: \_\_\_\_\_
- Yes No Endocrine (Diabetes, Thyroid, etc.): \_\_\_\_\_
- Yes No Skin: \_\_\_\_\_
- Yes No Blood (Anemia, Dyscrasias, etc.): \_\_\_\_\_
- Yes No Behavioral (Depression, etc.): \_\_\_\_\_
- Yes No History of Stroke or Head Injury, Cancer: \_\_\_\_\_
- Yes No Pregnant or Breast Feeding; **THE O.D. REVIEWED THE PREVIOUS HISTORY DATED \_\_\_\_\_ AND THERE IS NO CHANGE.**

Joint Pains	Yes No
Swelling of Joints	Yes No
Chest Pain	Yes No
High Blood Pressure	Yes No
Sinus Trouble	Yes No
Ringing in Ears	Yes No
Enlarged Glands	Yes No
Frequent Infections	Yes No
Chronic/Frequent Cough	Yes No
Shortness of Breath	Yes No
Recurrent Stomach Pain	Yes No
Heartburn	Yes No
Change in Skin	Yes No
Changes in Weight	Yes No
Anxiety	Yes No
Sadness	Yes No

Medical History

Check if anyone in your family has had any of the following: (please specify maternal or paternal)

- Cataracts
- Retinal Problems
- Heart Disease
- Glaucoma
- Blindness
- Thyroid Disease
- Macular Degeneration
- High Blood Pressure
- Neurological Diseases
- Lazy Eye
- Diabetes
- Arthritis

Family History

Dilation is a recommended procedure for most patients to help rule out certain eye diseases. Dilation takes about 30 minutes. Most people experience an increased light sensitivity and blurred vision, especially near vision, for 4 to 6 hours and sometimes longer. We recommend that you have someone to drive you home. If you choose to drive, drive at your own risk. Disposable shades will be provided for your comfort. I want to have my eye's dilated check one  Yes  No.

I have read, agree and answered the above to the best of my knowledge. I have answered correctly and truthfully:

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dr's. Signature: \_\_\_\_\_

# Abba Eye Care

## PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best and most comprehensive care possible. We encourage you to ask questions. In order to bill your insurance carrier, we need complete and accurate information.

**Patient Name:** \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Patient's Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address if Different: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address If Different \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMERGENCY CONTACT PERSON:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

### **FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES (Parent accompanying minor is responsible)**

**Vision Insurance Company** \_\_\_\_\_ Insurance ID No. \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Social Security No. \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

**Medical Insurance Company** \_\_\_\_\_ Insurance ID No. \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Social Security No. \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

# Financial Policy for Abba Eye Care

We are pleased that you have chosen Abba Eye Care to provide your care and services. We would like to take a moment to inform you of our payment policies. We accept cash, check and credit card for payment on your account.

**EYE EXAMINATION:** Some health insurance carriers will not cover eye examinations for the purpose of obtaining glasses. Most carriers will not cover the refraction fee (strength of the lenses) for determination of appropriate lenses. If you have a vision plan all or a portion of these charges may be covered. You will be responsible for those charges determined by your insurance as non-covered which is your portion.

**NO INSURANCE/NON-CONTRACTED:** If you don't have insurance, we expect you to pay for your visit, glasses or contacts at the time of service. Non-contracted insurance will be billed if appropriate information is given, however, payment is expected at the time of service. If we are requested to bill insurance at a later date, a billing fee may be added.

**MEDICARE:** We are participating with the Medicare program. We will submit your claim/services to Medicare. You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary /supplemental is directed to you, we will expect you to forward payment to us. Medicare does not cover refraction (strength of the lenses) – this fee will be your responsibility at the time of service. Medicare only covers frames and lens after cataract surgery. You will be responsible for payment of these items in addition to your co-insurance or deductible for your examination.

**MEDICAID AND MEDICAID HMO:** We do participate with the Medicaid program and Medicaid HMO. Each visit *you must provide us with a copy of your Medicaid card indicating that you are still eligible for Medicaid.* Should services be rendered, and you are no longer eligible for Medicaid coverage or have changed to Medicaid HMO without notifying us, you will be responsible for payment based on our normal fee schedule. All co-pays are to be paid on the day of the service.

**CONTRACTED INSURANCE (HMO, PPO, EPO, POS):** If you have insurance or vision plans that we are contracted with; we will submit your insurance claims for you if you supply us with the appropriate information. This includes a copy of your card an address to submit claims to, ID Number/Social Security Number and a telephone number to allow us to verify coverage. You are still responsible for your co-payment at the time of service, and any amounts not covered by your insurance, including deductibles. If your coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:** I hereby assign my insurance benefits to which I am entitled. I authorize and direct my insurance carrier(s) including Medicare, private insurance, and other health/medical plans to issue payment check(s) directly to Abba Eye Care for services rendered to my dependents or me, regardless of my insurance benefits, if any.

Abba Eye Care is authorized to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claim and a photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.

I have requested medical services from Abba Eye Care on behalf of my dependents or myself and I understand that by making the request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

In the event my account becomes delinquent, I will be responsible not only for the charges incurred, but also any costs involved in collection of my account. These include but are not to limited to, interest charges, re-billing fees, court costs, attorney fees, and collection costs. Insurance coverage is a matter between my insurance company and myself; I am ultimately responsible for the payment of my account.

**I have been given the opportunity to read, understand and ask questions about the payment and privacy policies set forth. I understand my responsibility for the privacy and payment policies with Abba Eye Care.**

\_\_\_\_\_  
Signature (Responsible Party Over the 18 years Old or Accompanying Parent /Guardian)

\_\_\_\_\_  
Date