VISION BENEFIT MAXIMIZER

In order to allow us to maximize your vision benefits, please fill out this form as completely as possible.

Patient Name: **Appointment:** **Time:**

Date of Birth	Age	Social Security Number
Home Phone		Home Address
Cell Phone		
Work Phone		
Email Address		Gender
Employer		Occupation
If patient is a minor (for financial purposes)		
Parent/Guardian Full Name		Relationship to Patient
Parent/Guardian Address		Parent/Guardian DOB
		Parent/Guardian Phone Number
		Parent/Guardian Employer
Parent/Guardian SSN (optional)		Parent/Guardian Employer Phone Number
Primary Vision Insurance		Secondary Vision Insurance *(Optional)*
Name of Insurance		Name of Insurance
Policy Holder Name		Policy Holder Name
Policy Number		Policy Number
Group Number		Group Number
Primary Medical Insurance		Secondary Medical Insurance *(Optional)*
Name of Insurance		Name of Insurance
Policy Holder Name		Policy Holder Name
Policy Number		Policy Number
Group Number		Group Number
Policy Holder Information (If different than patient) *If you are covered under the policy of spouse, partner, parent or guardian, please tell us about them.*		
Policy Holder Full Name		Home Address
Social Security Number		
Relationship to Patient		
DOB		Employer
Home Phone		Employer Phone
Cell Phone		Employer Address
Work Phone		

Initial: _____

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you:

Breathing Problems	☐ Yes ☐ No	**Blood Disorder**	☐ Yes ☐ No	**Musculoskeletal Conditions**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Sickle Cell	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Skin Conditions	☐ Yes ☐ No	**Allergy/Immunology**	☐ Yes ☐ No	**Ear/Nose/Throat Problems**	☐ Yes ☐ No
Eczema	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Rosacea	☐ Yes ☐ No	HIV	☐ Yes ☐ No	Dental Problems	☐ Yes ☐ No
Endocrine Disorder	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	**Neurological Disorder**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Kidney/Bladder Problems**	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Thyroid Disorder	☐ Yes ☐ No	**Surgical Operations**	☐ Yes ☐ No	Multiple Headaches	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	Myasthenia Gravis	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	**Psychiatric Disorder**	☐ Yes ☐ No	Head Injury	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Depression	☐ Yes ☐ No	**Sexually Transmitted Diseases**	☐ Yes ☐ No

Have you had any eye injuries, eye surgeries, eye diseases, floaters or flashes of light?

Are you currently being treated for any other medical condition? ☐ Yes ☐ No If yes, what?

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Please list any medications you are now taking. *(Including hormones, birth control, aspirin, or other anti-inflammatory, and eye drops)*

Is there any possibility that you might be pregnant? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

FAMILY HISTORY

Has anyone in your family had the following illnesses?
Please check all that apply and indicate their relationship to you:

Blindness	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Other Eye Disease	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No				

Initial: _____

RELEASE OF INFORMATION

Visual Fields Test

A comprehensive exam may not detect diseases early enough to prevent permanent vision loss. A visual field test evaluates your peripheral vision and may alert us to the presence of potentially vision-threatening diseases such as glaucoma, tumors, neurological diseases, and retinal detachment. This test can also detect certain systemic diseases such as hypertension, and diabetes, all of which can also lead to vision loss.

There is an additional fee for this test. ☐ **Yes, I DO want the Visiual Field Test.**

Optos Retinal Image

Your doctor recommends the Optomap Retinal Exam as part of your eye examination today. The Optomap ultra-wide digital retinal imaging system captures more than 80% of your retina in one panoramic image while creating a permanent record of your eye health. Traditional methods typically reveal only 10-15% of your retina at one time. With this enhanced ability to view your retina digitally, it may not be necessary to dilate your pupils today.

There is an additional fee for this test. ☐ **Yes, I DO want the Optos Retinal Image.**

HIPAA

The HIPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide at least one individual with whom we may share your medical records.

Authorized Individual _____ Phone Number _____

Authorized Individual _____ Phone Number _____

Statement of Financial Responsibility

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree I may be contacted at any number or address I have provided. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe. I understand that I am solely responsible for the cost of all non covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out of pocket. I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all claims if we are a participating provider for your plan. However, if my insurance denies payment for any claims submitted, I will be responsible for full payment. Otherwise, my eyecare provider will supply me with an itemized statement which I may submit to my insurance carrier.

☐ **I have read and understand the Statement of Financial Responsibility**

Signature of Patient (or Parent/Guardian) _____ Date _____

Signature of Physician _____ Date _____