WELCOME TO ....

Patient Name (last) ____________________________, (first) ______________________ (m.i.) _____

Patient Address _______________________________ City ______________ State ____ Zip________

Pt DOB (mm/dd/yy): ______________________ Age: ____ SSN: ___________________ Male / Female

Cell Phone _____________________ Home Phone _________________ Work Phone _______________

Email ____

Preferred method of contact: **Cell # / Home # / Work # or Email** (circle one)

Occupation: ___________________________________ Reason for visit: _______________________

Primary Care Physician: _________________________________ Phone # _______________________

How did you find us? ____

Do you plan on using any insurance? **Y** or **N**

Medical insurance: **Aetna BCBS Humana UHC Medicare** or **Other** _______________________

Vision insurance: **Aetna Vision / BCBS / EyeMed / Spectera / VSP / VCD / VCP / Other** __________

Are you the primary account holder on your insurance? **Y** or **N** (*If NO, please fill primary info below*)

Primary member's name (last) _____________________, (first) ____________________, (m.i.) ______

DOB (mm/dd/yy): _______________________ SSN: _________________ Relationship: ____________

Vision Examinations: For "routine eye examination", glasses prescriptions and/or contact lens fitting are billed through your vision insurance plan. Contact lens fitting/exams require additional follow up care. Vision insurance can only be used for prescribing vision correction (refractions). Medical insurance can't be used for "routine refractions" and the purchase of contacts/glasses.

Medical Examinations: For treatment of eye infection, glaucoma, macular degeneration, diabetic retinopathy, and/or other eye problems. Medical eye examinations require more time, documentation and additional professional judgement to identify the reason and the appropriate treatment. Vision insurance plans such as EyeMed and VSP cannot be used for medical examinations.

ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE

PATIENT ASSUMES FULL RESPONSIBILITY FOR PAYMENT OF SERVICES, COURT COST, ATTORNEY FEES, AND ANY OTHER COST INCURRED DURING COLLECTION OF DELINQUENT ACCOUNTS. AN ADDITIONAL $35 CHARGE WILL BE ADDED TO ANY RETURNED CHECK. ***PROFESSIONAL SERVICE FEES ARE NOT REFUNDABLE. EYE GLASSES ARE CUSTOM ORDERED TO FIT EACH INDIVUDUAL AND CAN'T BE RETURNED OR REFUNDED*** **(REFER TO OUR OFFICE POLICIES).** NO REFUNDS/EXCHANGES ON OPEN BOXES OF CONTACTS. PRESCRIPTION RECHECKS AVAILABLE AT NO CHARGE FOR UP TO 30 DAYS FROM THE ORIGINAL EXAM DATE, FEES APPLY AFTER 30 DAYS. MEDICARE DOES NOT COVER ROUTINE EYE EXAM!

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY & INFORMATION RELEASE CONSENT

I AUTHORIZE ANY HOLDER OF MEDICAL OPTICAL INFORMATION TO RELEASE INFORMATION ABOUT ME TO DR. DAVID J ANDERSON & ASSOCIATES AND I AUTHORIZE DR. DAVID J ANDERSON & ASSOCIATES TO RELEASE MEDICAL OPTICAL INFORMATION ABOUT ME TO OTHER HEALTHCARE PROFESSIONALS, ATTORNEYS OR INSURANCE COMPANIES.

I HEREBY ACKNOWLEDGE THAT I READ AND UNDERSTAND THE ABOVE INFORMATION. I ALSO HAVE BEEN PRESENTED AND OFFERED A COPY OF THE NOTICE OF PRIVACY POLICY FOR THE OFFICE OF DR. DAVID J ANDERSON & ASSOCIATES.

SIGNED: ____ DATE: _____/_____/_____

WELCOME TO .... arcadia eyecare

Patient Name ______________________________ **Date** ____________ **Age** ______

Review of Systems

Indicate what disease(s) you have or are being treated for .....

√ **Check "ALL" Appropriate Boxes**

Constitutional ☐**None**
☐Weight Loss
☐Fever
☐Fatigue

Ear Nose Throat ☐**None**
☐Chest cold
☐Flu
☐Sinus

Cardiovascular ☐**None**
☐Heart disease
☐Cholesterol
☐Stroke
☐Hypertension

Respiratory ☐**None**
☐Asthma
☐Bronchitis
☐Emphysema

Gastrointestinal ☐**None**
☐Ulcer
☐Digestive
☐Colitis

Genitourinary ☐**None**
☐Urinary tract infection
☐Kidney problem
☐Std Herpes

Musculoskeletal ☐**None**
☐Arthritis
☐Muscular dystrophy
☐Fibromyalgia

Integumentary ☐**None**
☐Acne Rosacea
☐Eczema
☐Psoriasis
☐Shingles in past

Neurological ☐**None**
☐MS
☐Epilepsy
☐Seizures
☐Myasthenia Gravis

Psychiatric ☐**None**
☐Depression
☐Panic Disorder
☐Anxiety
☐Insomnia

Endocrine ☐**None**
☐Diabetes
How Long ______
Type 1 or Type 2
Last A1C________
Last Gluclose______
☐Thyroid dysfunction
Hypo or Hyper

1. Are you **ALLERGIC** to any **Medications**? ☐No ☐**Yes**, List ______________________________
2. Do you take any Medications? ☐No ☐**Yes**, List ______________________________
____
3. Do you have any of the following diseases? ☐No ☐**Yes** If yes, please circle: **STD / Hepatitis / HIV / Syphilis**
4. List any EYE or major surgeries you have had. **RK** ______ Year; **Lasik** ______ Year; **Cataract** ______ Year
5. List any other major illness you have had or presently have ______________________________
6. When was you LAST eye exam? _________ (mm/yy) When was your LAST physical exam? __________ (yy/mm)

Social History

1. Do you use **tobacco** products? ☐No ☐**Yes** If yes, ☐Cigarettes ☐Cigars ☐Vape How long? ____________
2. Do you drink **alcohol**? ☐No ☐**Yes** If yes, ☐Daily or ☐Occasionally or ☐Socially How long? ____________
3. Do you use **narcotics**? ☐No ☐**Yes** ________________________ Type (i.e., Cocaine, Morphine)

Family History and Occular History

If unknown or none, check this box ☐**None**

		Family Member			Family Member
☐Blindness	☐Self	______	☐Corneal problem	☐Self	______
☐Cataracts	☐Self	______	☐Lazy eye	☐Self	______
☐Glaucoma	☐Self	______	☐Diabetes	☐Self	______
☐Macular Degeneration	☐Self	______	☐Heart Disease	☐Self	______
☐Retinal Detachment	☐Self	______	☐Cancer	☐Self	______

Any question left BLANK will be assumed to be Negative or Normal.
I, the patient, acknowledge the above Medical History is accurate and complete

Patient Signature (or Guardian if under 18 yr old) ______________________________