Patient Information Forms

Name ____ Date ____/ _____/ ________

Address ______________________________________ Cell Phone ________________________

City _____________________ State ______ Zip ________ Home Phone ______________________

Guardian (if applicable) ___________________________ Occupation _______________________

Date of Birth ____/ ____/ _______ Last Eye Exam _____________________

Do you have vision insurance? ❑No ❑Yes If yes, insurance carrier ___________________________

Do you have health insurance? ❑No ❑Yes If yes, insurance carrier ___________________________

Do you have Medicare? ❑No ❑Yes

Email:____

MEDICAL HISTORY

Do you have any allergies to medications? ❑No ❑Yes If yes, please explain

____

Please List All Medications that you are currently taking (please include oral contraceptives, over-the-counter medications, vitamins, and home remedies)

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____

____

List all major injuries, surgeries, and/or hospitalizations you have had

____

____

List any of the following that you have had or now have – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury

____

Do you wear glasses? ❑No ❑Yes If yes, how old are your current glasses? _____________________

Do you wear contacts? ❑No ❑Yes If yes, how old are your lenses? ___________________________

Type of contacts: ❑Rigid ❑Soft ❑Extended Wear ❑Other_________________________

Are you happy with your current contacts? ❑Yes ❑No If not, what is bothersome about them?

____

Are you pregnant or nursing? ❑No ❑Yes ❑Does not apply to me

Please turn over the pages, as information is needed on both sides of the pages.

MEDICAL HISTORY

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor, if preferred.

❑Yes, I prefer to discuss my social history directly with the doctor.

Do you drive? ❑No ❑Yes If yes, do you have visual difficulty when driving? ❑No ❑Yes

If yes, please describe: ____

Do you use tobacco products? ❑No ❑Yes If yes, type/amount/how long?______________________

Do you drink alcohol? ❑No ❑Yes If yes, type/amount/how long?______________________

Do you use illegal drugs? ❑No ❑Yes If yes, type/amount/how long?______________________

Have you ever been exposed to or infected with: ❑Gonorrhea ❑Hepatitis ❑HIV ❑Syphilis ❑ Herpes

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Review of Systems

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

Constitutional	No	Yes	Unsure
Fever, Weight Gain/Loss	❑	❑	❑
Integumentary			
Skin	❑	❑	❑
Neurological			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Eyes			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Holes	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Drainage	❑	❑	❑
Redness/Itching/Burning (circle)	❑	❑	❑
Foreign Body Sensation	❑	❑	❑

Ear, Nose, Mouth, Throat	No	Yes	Unsure
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Vascular/Cardiovascular			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
Gastrointestinal			
Chronic Diarrhea	❑	❑	❑
Chronic Constipation	❑	❑	❑

Eyes	No	Yes	Unsure
Sandy/Gritty Feeling	❑	❑	❑
Tearing/Watery	❑	❑	❑
Glare/Sensitivity	❑	❑	❑
Eye Pain/Soreness	❑	❑	❑
Chronic Infection (eye/lid)	❑	❑	❑
Sties/Chalazion	❑	❑	❑
Flashes of Light/Floaters	❑	❑	❑
Tired Eyes	❑	❑	❑
Endocrine			
Thyroid/Other Glands	❑	❑	❑
Allergic/Immunologic	❑	❑	❑

Genitourinary	No	Yes	Unsure
Genitals/Kidney/Bladder	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Psychiatric	❑	❑	❑

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition	No	Yes	Unsure	Relationship
Blindness	❑	❑	❑	________________
Cataract	❑	❑	❑	________________
Crossed Eyes	❑	❑	❑	________________
Glaucoma	❑	❑	❑	________________
Macular Degeneration	❑	❑	❑	________________
Retinal Detachment/Disease	❑	❑	❑	________________
Arthritis	❑	❑	❑	________________
Cancer	❑	❑	❑	________________
Diabetes	❑	❑	❑	________________
Heart Disease	❑	❑	❑	________________

If you answered yes to any of these above or have a condition that is not listed such as high blood pressure, kidney disease, lupus, thyroid disease, or any other please explain and list medications that are being taken for any of these:____

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How did you hear about us? ❑Facebook ❑Google ❑Friends & Family ❑Other: _________

Note: **Please do not wear perfumes or colognes to the appointment, or any strong fragrances. Thank you!**

Insurance and Financial Responsibility Policy Agreement

Please fill out and read this form. Please provide the receptionist with most current insurance card/cards (medical and vision), and photo identification when you have completed all forms, front and back.

Patient's Name ___________________________________ Patient's Social Security #__________________________

Subscriber's Name (if different from patient) ____

Subscriber's Date of Birth _______________ Subscriber's Social Security # __________________________________

Primary Medical Insurance Plan__________________________ Member ID# ________________________________

Primary Vision Insurance Plan ___________________________ Member ID # _______________________________

Please Note: *All payments are to be paid at the time of service, including all co-payments and deductibles. If your insurance company does not pay your claim within 60 days, you will be responsible for paying the balance. If your insurance company pays us more than what is owed, we will send you a check immediately. Accounts that are past due of 60 days or more will be referred to collections. Insurance is a contract between you and your insurance company. Keep in mind that we are not party to the agreement. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or "usual and customary fees", other than to supply the factual information necessary. Also, authorizations given by your insurance company do not guarantee payment on your claim. You will be responsible for any claims that are unpaid by your insurance carrier, whether it be vision or medical benefits. X______________________ Initials*

Medicare Patients: *Medicare DOES NOT cover "routine eye examination" or refractions. You will be responsible for the $60 fee plus any deductible that is not covered by your secondary insurance. A 20% fee will be charged for those that do not have a secondary insurance. Medicare covers only 80% of the visit. Medicare does not cover any optical products. You must have a vision plan for optical products to be covered. Dr. Vachhani is a participating provider and does accept assignment. X______________________ Initials*

Assignment and Release of Medical Information: *I hereby authorize Dr. Sonya Vachhani to release any information that is required to process my insurance claim. I also authorize insurance benefits to be directly paid to Dr. Sonya Vachhani. I understand that I am financially responsible for services that are not covered by my insurance. I have received a copy of Dr. Sonya Vachhani's privacy policy regarding the care of confidentiality of my records and personal information. This authorization is in effect until I choose otherwise to revoke it. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original. Your signature will remain on file until otherwise revoked in writing. X _____________________ Initials*

Vision Insurance: If you have vision insurance, we will file your claim for your comprehensive examination, as well as eyeglasses and contact lenses. **If you have a medical diagnosis, such as diabetes or glaucoma, we cannot bill your vision insurance for your eye examination**. We will have to file a claim to your medical insurance and any additional services that are necessary. You cannot use your vision insurance combined with your medical insurance. I have discussed the additional fees and have agreed to proceed with the necessary diagnostic testing.

X_____________________ Initials

Patient's/Guardian Signature: ____ **Date:** ____________________

By signing this agreement, you understand the policies of the office of Dr. Sonya Vachhani and agree to all terms, including financial responsibility for all charges rendered.

Insurance & Self Pay

When you are using insurance, it is important and necessary for us to have both your medical and vision insurance information. This information is used only for your healthcare needs.

- If you have a medical condition that affects your vision, your eye examination will be billed to your medical insurance, as vision insurance will not cover this. Should you need to come in for an office call (example: eye redness, irritation, flashes of light, or pain in the eye), we will need to file it with your medical insurance. If you have no insurance, you will be financially responsible. You may ask for an estimate of costs at the time of the exam, but this is only an estimate on what the doctor feels will be necessary for treatment/and or the necessary services needed for you.

Vision Insurance covers annual vision, eye health, wellness examinations, and refractions only. Depending on your vision plan, it MAY or MAY NOT cover the contact lens evaluations. If being fit for contact lenses, there will be a yearly contact lens evaluation fee. Follow-up appointments are required when getting your initial contact lens fitting and the follow-ups are covered as part of the initial evaluation. In some cases, additional testing may be necessary to rule out a possible pathology. These tests are not covered by your vision insurance. You will be informed of any cost that may be out of pocket before any testing is performed.

X ____ Date: _________________________

Patient Signature or Guardian (if patient is a minor)

Self-Pay Contact Lens Patients:

I am aware that there is a yearly contact lens evaluation fee, and this fee cannot be waived.

X____ Date: _________________________

Patient Signature or Guardian (if patient is a minor)

Out of Network Medical Insurances:

If your primary medical insurance is out of network **(including but not limited to BCBS, Anthem BCBS, Humana Gold HMO, Medicare Aetna HMO (Coventry), Medicaid, Wellcare, and Staywell)** you will be financially responsible for all charges at the time of your visit.

X ____ Date: _________________________

Patient Signature or Guardian (if patient is a minor)

Medical Diagnostic Testing:

I give my permission to do any necessary diagnostic testing that Dr. Sonya Vachhani suggests during my visit and I understand that some or all of the charges may not be covered by my insurance and may possibly be an out-of-pocket expense. I agree to pay any uncovered charges at the time of my visit.

X ____ Date: _________________________

Patient Signature or Guardian (if patient is a minor)

Notice of Privacy Practices

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice briefly describes how we protect your health information and what right you have regarding it. If you would like a more thorough version, please ask one of our staff members.

Treatment, Payment, and Health Care Operations

The most common reason why we use or disclose your health information is for treatment, payment, or operations. We routinely use your health information inside our office for these purposes without any special permissions.

Patient Records Release

If we need to disclose your health information outside of our office for any reason, we will ask you for a special written permission.

Appointment Reminders

We may call, text, email, and/or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also communicate via any of these options to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder of a post card, and/or leave you a reminder message on your voicemail.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

Acknowledgement of Receipt

I acknowledge that I received a copy of **Waterside Eyecare & Optical's** Notice of Privacy Practices.

X____________________________ X____________________________ ______________

Patient Name Signature Date