

NEW PATIENT INFORMATION

Today's Date: _____ Email address: _____

PERSONAL INFORMATION – (Please Print)

Patient Name: _____ Age: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: (_____) _____ Work Phone:(_____) _____

Date of Birth: _____ S.S. #: _____

Sex: Male / Female

Marital Status: Single Married Divorced Widowed

Employment Status Employed Unemployed Retired Disabled

Employer: _____ Occupation: _____

Work Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Employer: _____ Work Phone: _____

Primary Care/ Family Doctor: _____

Referred by:

Friend/Relative _____ Doctor: _____

Internet Insurance Website Other: _____

Who to notify in an emergency (nearest relative or friend)?

Name: _____ Relationship: _____

Phone: _____

Complete if under 18 years or a student

Name of Father: _____ Social Security # _____

Phone: _____

Name of Mother: _____ Social Security # _____

Phone _____

INSURANCE INFORMATION (Please bring insurance cards and drivers license to the front desk)

Primary Insurance: _____ # _____

Co-pay Amount: _____

Name of:

Policyholder: _____ **Social Security #** _____

Date of Birth: _____

Secondary Insurance: _____ **#** _____

Co-pay Amt: _____

Name of:

Policyholder: _____ **Social Security #** _____

Date of Birth: _____

Patient Name: _____

FINANCIAL ASSIGNMENT AND AGREEMENTS

- **I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.**
- **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to (Rothchild Eye Institute) for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.**
- **I understand that I am financially responsible for all charges not covered by insurance.**
- **I give permission to (Rothchild Eye Institute) to access records regarding my medical conditions.**
- **I authorize (Rothchild Eye Institute) to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.**
- **I agree to the release of my medical information to my personal physician(s), or optometrist(s).**

➤ **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

1. _____ 2. _____

3. _____ 4. _____

I acknowledge that a copy of (Rothchild Eye Institute) Notice of Privacy Practices has been provided to me for review and that a copy is available at my request.

Signature: _____ **Date:** _____
(Patient or legal guardian)

Witness: _____ **Date:** _____
(Practice Representative)

Medical History Questionnaire

Name _____ Date _____

Date of Birth _____

Date of last eye exam _____ By Dr. _____

Primary Care Doctor _____

List any medications you currently take (prescription and over the counter): _____

Do you have any allergies to any medications? YES NO

If yes, please list the medications: _____

List all major illnesses (glaucoma, diabetes, heart attack, etc.) or injuries (concussions, etc.):

List any surgeries you have had (Ex: cataract, tonsillectomy): _____

Do you currently have any problems in the following areas? If "YES" please provide information.

	YES	NO	Explanation of problem.
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating 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 or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eye lid			
General/Constitutional			
Fever			
Weight loss			
Other			
Ears, Nose, Throat (Sinus, ear infection, chronic cough, dry mouth, Etc.)			
Heart and Blood (Heart, vessels, etc.)			

Lung (Asthma, emphysema, etc.)			
Gastrointestinal (Stomach ulcers, intestinal disease)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (Arthritis, etc.)			
Skin (Acne, warts, skin cancer, etc.)			
Neurological (Stroke, multiple sclerosis, etc.)			
Psychiatric (Anxiety, depression, insomnia, ect.)			
Endocrine (Diabetes, thyroid, etc.)			
Blood/Lymph (cholesterolemia, anemia, etc.)			
Allergic/Immunologic (Hay fever, lupus, Sjogrens, AIDS)			

Family History

Any family eye disease? If "YES" please list: M = mother F = Father S = Sibling GP =

Grandparent

Disease	YES	NO	Explanation of problem.
Blindness			
Cataract			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

Social History

Current occupation:

Marital status (married, divorced, single, widowed): _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you drink alcohol? YES NO If yes, occasional, more than 4/day

Do you smoke? YES NO If yes, how much per day _____

Have you ever had a blood transfusion? YES NO

Patients Signature/Or Person Authorized to sign for patient

REFRACTIONS

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What is Our Policy?

At Rothchild Eye Institute we are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, refraction will be performed when medically necessary (*typically this includes all new patients*, those presenting with decreased vision and on a yearly basis thereafter). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is **\$55.00** and is collected at the time of your visit, in addition of any co-payments or deductible due for the medical portion of your examination. As a courtesy we will send in a claim to your insurance for the refraction and if by chance they do pay for it we will reimburse you timely.

I have read the above information and understand that the refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

Signature

Date

CONTACT LENS INFORMATION

Are you currently a Contact Lens wearer? YES or NO

If yes, for how many years? _____

Which brand of Contact Lenses are you currently wearing?

Did you bring your Contact Lens boxes in with you today? YES or NO