Welcome to our Practice

We are pleased that you have chosen to come to our office for your eye care needs. Each patient's needs remain the primary focus of our team. The mission of our practice is to meet your comprehensive visual and ocular health needs and to exceed your expectations in a friendly, compassionate, educational atmosphere, nurturing a lasting relationship with you.

People are sometimes mislead into thinking eye care is the same from one place to another, but it's not. Seeing the eye chart is one thing, but vision and medical eye health care varies dramatically. We see it as total vision and medical eye health. We want you to know that we are not only concerned about your current vision, but maintaining good vision for many years to come. In order to adequately assess the overall health of your eyes, we often need to dilate your eyes. The dilating drops may cause blurry vision and light sensitivity. These side effects may last 3-6 hours depending on your eye color and age. You may want to bring along a driver to be present when your eyes are dilated.

Although we do our best to stay on schedule, sometimes delays cannot be avoided due to the complexity of our patients' cases or emergencies that the doctor has to work into his/her schedule. We apologize for any wait time that you may experience, but please understand that your time is very important to us and the doctor will spend as much time with you as needed to answer all your questions and provide a thorough diagnosis and plan for you.

What to Bring to Your Appointment

All Patients:

1. Picture ID (for adults), Vision and Medical Insurance Card
2. Current eyeglasses and sunglasses
3. List of Medications
4. Completed Health and History Form

Contact Lens Patients:

1. Current contact lens prescription and the brand of your lenses.

Please fill out the enclosed paperwork and bring it along with the above mentioned items in order to expedite the check-in process on the day of your appointment.

All estimated professional fees are due at the time of service. Please be prepared to pay your copay and any coinsurance on the day that eye care is received. If necessary, we will send you a statement for any overage after your insurance has been processed.

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EYES ON HENRY

Patient Information

Today's Date ________________________________

Last ________________ First___________________
MI ________________Preferred Name ____________
Street ____
City _______________ State ___________________
Zip Code _____________________________________
Home Phone ___________________________________
Work Phone ___________________________________
Cell Phone____________________________________
Email Address ________________________________
Patient's SSN ________________________________
Employer (or School) __________________________
Occupation (or Grade) _________________________
Spouse (or Responsible Party's Name)
____
Spouse (or Responsible Party's Work)
____
Marital Status: ❑ Married ❑ Single
❑ Divorced ❑ Widowed
Date of Birth ____________________Age _________
Sex M F
Emergency Contact Name ______________________
Emergency Contact Number ____________________

What is the major purpose of this visit?
____
____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____________________

If not referred, how did you choose our office?
❑ Another Dr. ❑ Insurance List
❑ Saw Sign/Building ❑ Yellow Pages
❑ Other ____________________________________

The mission of this practice is to meet our patients' comprehensive visual and ocular health care needs and exceed their expectations in a friendly, compassionate, and educational atmosphere, nurturing lasting relationships with patients of all ages.

Insurance Information

Vision Insurance ______________________________
Policy/ID Number_______________________________
Group Number _________________________________
Subscriber's Name _____________________________
Subscriber's SSN_______________________________
Subscriber's Birth Date _________________________
Subscriber's Employer __________________________

Primary Medical Insurance _______________________
Policy/ID Number_______________________________
Group Number _________________________________
Subscriber's Name______________________________
Subscriber's SSN_______________________________
Subscriber's Birth Date _________________________

Secondary Medical Insurance_____________________
Policy/ID Number_______________________________
Group Number _________________________________
Subscriber's Name______________________________
Subscriber's SSN ______________________________
Subscriber's Birth Date _________________________

Lifestyle Questions

Do you…(check box if your answer is yes)
❑.spend time on the computer? How many hrs/day? __
❑.think you might benefit from thinner, lighter lenses?
❑.find yourself bothered by glare or reflection, particularly when night driving?
❑.spend time outdoors? How many hrs/week? ___
❑.have sun wear (prescription and/or non-prescription)?
❑.prefer not to wear your glasses at times?
❑.want information on Laser Vision Correction surgery?
❑..have a spare pair of glasses in your current Rx?
❑..have family members or friends in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?
❑ Blurry Vision ❑ Flashes of Lights
❑ Sunlight Sensitivity ❑ Eye Infections
❑ Trouble seeing at night ❑ Eye Injury
❑ Itchiness ❑ Cataracts
❑ Grittiness ❑ Crossed eye/Eye Turn
❑ Burning ❑ Lazy Eye
❑ Tearing ❑ Glaucoma
❑ Double Vision ❑ Macular Degeneration
❑ Dry Eyes ❑ Retinal Detachment
❑ Floaters/Spots ❑ Iritis/Uveitis
❑ Other eye disorders_____________________________

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician________________________
Town________________________
Date of Last Physical Check-up________________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)________________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?________________________
____

Preferred Pharmacy ________________________
Street ________________________
City: ________________________

Have you had any major surgeries? ❑ Yes ❑ No
Please list ________________________
____

Tobacco Use? ❑ Yes ❑ No Type: ________________
Alcohol Use? ❑ Yes ❑ No Frequency: ____________
Drug Use? ❑ Yes ❑ No Frequency: ____________

Have you ever been diagnosed or treated for the following health problems?

❑ Allergies ❑ Arthritis
❑ Blood/Lymph ❑ Cancer
❑ Cholesterol ❑ Diabetes
❑ Digestive ❑ Eczema/Rashes
❑ Fatigue ❑ Fevers
❑ Genitourinary ❑ High Blood Pressure
❑ Integumentary (Skin) ❑ Kidney
❑ Muscle/Bone ❑ Neurological
❑ Psychological ❑ Respiratory
❑ Thyroid

Patient Eye History

Date of Last Eye Exam________________________
By Whom?________________________

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?________________________
Solutions used________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you don't wear contacts, would you be interested in being fit for them ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship
Blindness	❑ ____________
Cataracts	❑ ____________
Corneal Problems	❑ ____________
Diabetes	❑ ____________
Glaucoma	❑ ____________
Heart Disease	❑ ____________
Lazy Eye	❑ ____________
Macular Degeneration	❑ ____________
Retinal Problems	❑ ____________

Please be advised if you are using insurance coverage for today's visit, we require a valid copy of your insurance card to ensure that your claims are filed properly. We will file your insurance for you as a courtesy, however if your insurance does not cover a particular service, you will be responsible for the balance, any copays, deductibles, and/or contact lens fitting fees. Payment of these is due at the time of the service.

By signing, you authorize your insurance company to make payment to this practice for services and material provided. You authorize the practice to deposit checks received on your account if made out to you, the patient. You authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on your behalf.

Signature________________________ Date: ________________________

Authorization for Release of Information

This form authorizes Eyes on Henry to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mail/answering machine messages.

I consent to the release of (please check all that apply):
___ Financial/Billing Information
___ Medical Care (treatment plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:
___ Patient's voice mail/answering machine
___ Voice mail/answering machine of (e.g. spouse, parent, sibling)

______________________________	______________________
Name/Relationship to patient	Phone#
______________________________	______________________
Name/Relationship to patient	Phone#

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Eyes On Henry. I understand a revocation is not effective in cases where the information has already been disclosed.
I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing This authorization shall be in effect until revoked by the patient.

____
(Signature of Patient (parent or legal guardian if patient is a minor)

Acknowledgement of Notice of Privacy Practices

Eyes on Henry will provide me a copy of their Notice of Privacy Practices up request. ____________
(Please initial)

Digital Retinal Imaging

In keeping with our mission to provide the latest technology in caring for your eyesight, we offer an elective procedure, digital retinal imaging. The retinal camera takes an image of the optic nerve and retina. The images are added to your medical records assisting your doctor in the early detection of glaucoma, diabetic retinopathy, macular degeneration, retinal tears, and other visual threatening conditions.
The cost for this procedure is $35. This is an additional out of pocket expense, and is not covered by vision or medical insurance. If these photos detect a medical condition, we may be able to file the fee to your medical insurance, but in most cases this cannot be determined prior to taking the photo.

Because of known risk factors, we strongly recommend these photos for the following:

- History or Family history of glaucoma
- History or Family History of High Blood Pressure
- History or Family History of Macular Degeneration
- History or Family History of Diabetes
- History or Family History of High Cholesterol
- Over the Age of 40
- Headaches
- Spots or Flashes of Light

________ I elect to have this $35 procedure. ______ I decline this additional procedure.