WELCOME TO CRYSTAL EYECARE

PATIENT INFORMATION

Reason for today's visit: ☐ Routine Eye Exam ☐ Glasses Purchase ☐ Contacts Purchase **OR** ☐ Medical

If Medical, Specify: Date: / /

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: Nickname:

Street Address: City: State: Zip:

Date of Birth: / / Gender: ☐ Male ☐ Female Last 4 SSN:

Home Phone: Cell Phone: Work Phone:

Email: Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

How Did You Hear of Our Office : ○ Online ○ Insurance ○ Local to Area ○ Referral Referred By:

HEALTH HISTORY

Family Dr:______________ Family Dr Phone:______________ Last Physical Date:______________

Tobacco Products: ○ Yes ○ No Do You Drink Alcohol: ○ Yes ○ No Women: Pregnant or Nursing: ○ Yes ○ No

IF DIABETIC:

DATE DIAGNOSED:___/___/___ LAST BLOOD SUGAR:______MG/DL LAST HEMOGOBIN A1C: ______%

Last Eye Exam Date:___/___/___ Last Eye Doctor Office:______________

PLEASE INDICATE YES OR NO IF YOU HAVE THE FOLLOWING CONDITIONS

EYES
- GLAUCOMA ○ YES ○ NO
- CATARACTS ○ YES ○ NO
- BLINDNESS ○ YES ○ NO
- DRY EYE ○ YES ○ NO
- EYE SURGERY ○ YES ○ NO
- RETINAL DISEASE ○ YES ○ NO
- MACULAR DEGENERATION ○ YES ○ NO
- STRABISMUS/ EYE TURN ○ YES ○ NO
- AMBLYOPIA/ LAZY EYE ○ YES ○ NO

CONSTITUTION
- CANCER ○ YES ○ NO
- FATIGUE ○ YES ○ NO
- DEVELOPMENTAL DISABILITIES ○ YES ○ NO

PSYCHOLOGY
- DEPRESSION ○ YES ○ NO
- ANXIETY ○ YES ○ NO
- ATTENTION DISORDER ○ YES ○ NO

INTEGUMENTARY
- SHINGLES ○ YES ○ NO
- BREAST CANCER ○ YES ○ NO

EAR, NOSE, THROAT
- SINUSITIS ○ YES ○ NO
- DRY MOUTH ○ YES ○ NO
- HEARING LOSS ○ YES ○ NO

ALLERGY
- DRUG ALLERGIES ○ YES ○ NO
- ENVIROMENTAL ALLERGIES ○ YES ○ NO

RESPIRATORY
- ASTHMA ○ YES ○ NO
- EMPHYSEMA ○ YES ○ NO
- SLEEP APNEA ○ YES ○ NO
- LUNG CANCER ○ YES ○ NO

MUSCULOSKELETAL
- ARTHRITIS ○ YES ○ NO
- GOUT ○ YES ○ NO
- OSTEOARTHRITIS ○ YES ○ NO

CARDIOVASCULAR
- HYPERTENSION ○ YES ○ NO
- HEART DISEASE ○ YES ○ NO
- VASCULAR DISEASE ○ YES ○ NO
- CONGESTIVE HEART FAILURE ○ YES ○ NO

ENDOCINE
- DIABETES TYPE 2 ○ YES ○ NO
- DIABETES TYPE 1 ○ YES ○ NO
- THYROID DYSFUNCTION ○ YES ○ NO

GASTROINTESTINAL
- CROHN'S ○ YES ○ NO
- ULCER ○ YES ○ NO
- COLITIS ○ YES ○ NO
- CELIAC DISEASE ○ YES ○ NO
- ACID REFLUX ○ YES ○ NO

GENITOURINARY
- KIDNEY DISEASE ○ YES ○ NO
- PROSTATE DISEASE ○ YES ○ NO

NEUROLOGY
- EPILEPSY ○ YES ○ NO
- TUMOR ○ YES ○ NO
- STROKE ○ YES ○ NO
- MIGRAINE ○ YES ○ NO
- AUTISM ○ YES ○ NO
- MULTIPLE SCLEROSIS ○ YES ○ NO

IMMUNOLOGIC
- SJOGREN'S SYNDROME ○ YES ○ NO
- RHEUMATOID ARTHRITIS ○ YES ○ NO
- LUPUS ○ YES ○ NO

OTHER

Blood Pressure: ____________

PLEASE LIST ALL

Medications	Allergies	Eye Surgeries

INSURANCE INFORMATION

Vision Insurance: ______________________	Medical Insurance: ______________________
Subscriber Name: ______________________	Subscriber Name: ______________________
Subscriber DOB: ______/______/______	Subscriber DOB: ______/______/______
Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse	Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse
Subscriber ID: ______________________	Subscriber ID: ______________________

Please read, and sign the following FINANCIAL POLICY. If you have any questions please feel free to ask us.

1) Payment due at time of service:
Payment is due at check-out after services rendered. We accept cash, check, and major credit cards. The patient/guarantor is responsible for all charges, including charges for minors and dependents.

2) Insurance plans:
Insurance (vision & medical) plans are agreements between you and your insurance company. If we participate with your plan, we are happy to submit claims when you provide current, complete plan information. If your plan requires a referral or authorization, please obtain it before your visit. Any eligibility or benefit information we provide is an estimate and not a guarantee of payment. You are responsible for any charges not paid by your plan, including deductibles, co-pays, coinsurance, non-covered services, out-of-network amounts, and denied claims.

3) Contact lenses:
Contact lens evaluations and fittings incur additional fees and are often not covered by insurance or vision plans. Contact lens evaluation fees are due at the time of service.

4) Cancellations and missed appointments:
We understand life happens. Please give at least 24 hours' notice to cancel or reschedule. Appointments missed or canceled with less than 24 hours' notice may be charged a $50 missed appointment fee per appointment. This fee is not billable to insurance and is due before a future appointment is scheduled.

5) Billing, statements, and returned payments:
Returned checks are subject to a $35 returned-payment fee, plus any bank charges we incur. After a returned payment, we may request future payments by cash or card. If a balance remains after insurance processes the claim, it is due when you receive your first statement. If the balance is not paid within 60 days, we may charge a $15 administrative fee for each additional statement we send.

ACKNOWLEDGEMENT

I have read and understand this Financial Policy and agree to be responsible for payment as described above.

Patient/Guarantor Signature: ______________________________ Date: ________________________

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a "Notice of Privacy Practices Policy". This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request.

ACKNOWLEDGEMENT OF RECEIPT I acknowledge that I received a copy of Crystal Eyecare, Notice of Privacy Practices.

Date__________ Patient Name____________________ Signature______________________________

The Doctors or staff may discuss my situation or condition with the following individual(s):

Name______________________________ Relationship______________________

Name______________________________ Relationship______________________