

## Optical Fashions

### ***PATIENT INFORMATION***

NAME _____	DATE _____		
ADDRESS _____			
(STREET)	(CITY)	(STATE)	(ZIP)
PHONE(HOME) _____ (BUSINESS) _____			
DATE OF BIRTH _____		AGE _____ SS # _____	
OCCUPATION _____		PLACE OF EMPLOYMENT _____	
GRADE _____		SCHOOL _____	
DO YOU WEAR SPECTACLES? _____		CONTACT LENSES?(HARD) _____ (SOFT) _____	
DATE OF LAST EXAMINATION _____			
DO YOU FEEL YOUR VISION IS POOR OR BOTHERSOME WITH YOUR GLASSES/CONTACT LENSES AT:			
DISTANCE _____		INTERMEDIATE _____ NEAR _____	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____			

### ***INSURANCE INFORMATION***

PERSON RESPONSIBLE FOR ACCOUNT _____	
RELATIONSHIP TO PATIENT _____	BIRTHDATE _____
ADDRESS (if different than patient) _____ PHONE _____	
CITY _____	STATE _____ ZIP _____
PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____	
BUSINESS ADDRESS _____ BUSINESS TELEPHONE _____	
VISION INSURANCE (YES/NO) _____ IF YES, NAME OF COMPANY _____	
MEDICARE # _____ SOCIAL SECURITY # _____	
CONTRACT # _____	GROUP # _____ SUBSCRIBER ID # _____
IS PATIENT COVERED BY ADDITIONAL INSURANCE (YES/NO) _____	
IF SO, NAME OF COMPANY _____ SUBSCRIBER NAME _____	
CONTRACT # _____	GROUP # _____ SUBSCRIBER ID # _____
I, the undersigned have insurance coverage with _____	
(name of insurance company)	
and assign directly to _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not if paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
_____	Date _____
Signature of Insured/Guardian	

### **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits to be made either to me or on my behalf to _____ for any services furnished me by that physician or company. 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 these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. if "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.	
_____	Date _____
Beneficiary's Signature	

**CONDITIONS**

IF YOU HAVE A FAMILY HISTORY OF THE FOLLOWING, PLEASE DESIGNATE WHICH MEMBER BY THE FOLLOWING INITIALS: SELF(P), MOTHER (M), FATHER (F), BROTHER (B), SISTER (S), AUNT (A), UNCLE (U), GRANDPARENT (GM OR GF);

**GENERAL:**

- 1. DIABETES \_\_\_\_\_
- 2. HIGH BLOOD PRESSURE \_\_\_\_\_
- 3. HEART DISORDERS \_\_\_\_\_
- 4. KIDNEY DISORDERS \_\_\_\_\_
- 5. THYROID DISORDERS \_\_\_\_\_
- 6. MULTIPLE SCLEROSIS \_\_\_\_\_
- 7. TUBERCULOSIS \_\_\_\_\_
- 8. ALLERGIES (YOURSELF ONLY) \_\_\_\_\_

**OCULAR:**

- 1. GLAUCOMA \_\_\_\_\_
  - 2. CATARACTS \_\_\_\_\_
  - 3. "CROSS EYES" \_\_\_\_\_
  - 4. "LAZY EYE" \_\_\_\_\_
  - 5. MACULAR DEGENERATION \_\_\_\_\_
  - 6. NIGHT BLINDNESS \_\_\_\_\_
  - 7. INJURY OR SURGERY TO YOUR EYES \_\_\_\_\_
- IF YES, WHEN AND WHAT TYPE: \_\_\_\_\_

**PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS**

- YES NO DO YOU HAVE ANY PERMANENT HEAD OR EYE INJURIES?
- YES NO DO YOUR EYES ITCH, BURN, OR WATER EXCESSIVELY?
- YES NO ARE YOU TROUBLED WITH FREQUENT HEADACHES?
- YES NO ARE YOU GREATLY BOTHERED BY BRIGHT LIGHTS?
- YES NO DO YOU SUFFER FROM EYE PAIN OR STRAIN?
- YES NO DO YOU EVER SEE DOUBLE?
- YES NO HAVE YOUR PUPILS EVER BEEN DILATED BY AN EYE DOCTOR?
- YES NO DO YOU HAVE PARTICULAR DIFFICULTY DRIVING AT NIGHT?
- YES NO DOES YOUR VISION PROBLEM(S) INTERFERE WITH YOUR JOB/SCHOOL?
- YES NO ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE?

PHYSICIAN'S NAME \_\_\_\_\_

LIST RECENT OR CURRENT HEALTH PROBLEMS \_\_\_\_\_

LIST CURRENT MEDICATIONS \_\_\_\_\_

LIST ANY SPORTS, HOBBIES OR ACTIVITIES IN WHICH YOU PARTICIPATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**PRE-EXAMINATION QUESTIONNAIRE**

(if contact lens wearer)

How long do you wear your contacts each day? \_\_\_\_\_

How many hours in today? \_\_\_\_\_

What solutions are you using? \_\_\_\_\_

Do you "rub" the lenses or use the "no rub" method of cleaning? \_\_\_\_\_

Do you do this in the morning or at night? \_\_\_\_\_

How old is your current pair of contact lenses? \_\_\_\_\_

How many lenses have you replaced in the past year? \_\_\_\_\_