AFFLECK MD EYE CARE
2900 Valencia Drive Idaho Falls, ID 83404

Aaron J. Affleck, M.D.
Phone: 208-523-6838
FAX: 208-561-9983
www.LOVEhealthyEYES.com

		Today's Date:	
Patient's First Name	Patient's Middle Name	Prefix (Mr., Mrs.)	Suffix (Sr. Jr.)
Patient's Last Name	Nickname	Date of Birth	Gender

Address: Street	City	State	Zip

Reminders for appointments will be sent through a non-encrypted e-mail, text and/or automatic phone calls. To Opt–Out of reminders methods mark the box. You can opt-out of one or all. If you opt-out of all, NO reminders will be sent. Your cell phone or email carry may apply charges.

☐ Home Phone- *Call Reminders*	☐ Cell Phone- *Text Reminder*	☐ Work Phone / Ext
☐ Email Address	Special Needs (*Wheelchair, Hard hearing, and etc.)*	

Marital Status	*If you prefer not to answer mark the box*		
	☐ Race	☐ Primary Language	☐ Ethnicity

RESPONSIBLE PARTY (R.P) INFORMATION: (Leave Blank if Patient is R.P.)
Normally the patient is the responsible party unless a minor.

Patient's Relationship to the Responsible Party

First Name	Middle Name	Prefix (Mr., Mrs.)	Suffix	Social Security #
Last Name	Nickname	Date of Birth		Gender

Address: Street	City	State	Zip

Home Phone	Cell Phone	Work Phone / Ext	Email Address

INSURANCE INFORMATION:

☐ *I AM SELF-PAY. I UNDERSTAND IF I SELECT SELF-PAY, AFFLECK, MD EYE CARE WILL NOT SUBMIT INSURANCE OR CLAIM INFORMATION.*

Affleck, M.D. Eye Care will be unable to bill your insurance is any information is left blank. If a section does not apply please mark the box "Does Not Apply." You must present a physical insurance card(s) at each visit. If you are unable to do so, we will have no formal documentation of your coverage. Dr. Affleck will be able to still exam you, however, you will be declared as a self-pay, and we require full payment of services before your visit. Thank you in advance for your understanding.

MILITARY INSURANCE: ☐ Does Not Apply	Name of Military Personal	Relationship to patient
Active Duty Status of Military Personal	Military Personal Social Security #	Military ID Card Number
Beneficiary's (Patient) TRICARE Plan Type:	The Beneficiary Type	Is a Tricare Referral Required?

Dr. Affleck and his staff want you to know we are grateful for our military members and all they do for our country. Thank you!

WHEN IT'S TIME TO SEE THE WORLD AS YOU DESERVE, IT'S TIME TO SEE DR. AFFLECK.

PATIENT: _____ DOB: _____

INSURANCE INFORMATION: Workers Compensation ☐ Does Not Apply **Required information*

Date of injury	Business or Employer's Name	Employer's Phone	Business or Employer's Address
Supervisor/manager/owner's name	Supervisor/manager/owner's phone	Case Worker or Contact Name	Case Worker or Contact Phone
Claim number (if available)	Is your employer aware of your injury? ☐ NO ☐ Yes	*Patient's Social Security #	Case Worker or Contact E-Mail

PRIMARY INSURANCE ☐ Self-Pay; Does Not Apply

Insurance Company Name		Specialist Copay
Insured's First Name	Insured's Last Name	
Date of Birth / Gender	Insured's Phone	
Insured's Address		

SECONDARY INSURANCE ☐ Does Not Apply

Insurance Company Name		Specialist Copay
Insured's First Name	Insured's Last Name	
Date of Birth / Gender	Insured's Phone	Date of Birth
Insured's Address		

TERTIARY INSURANCE ☐ Does Not Apply

Insurance Company Name		Specialist Copay
Insured's First Name	Insured's Last Name	
Date of Birth / Gender	Insured's Phone	
Insured's Address		

Other INSURANCE ☐ Does Not Apply

Insurance Company Name		Specialist Copay
Insured's First Name	Insured's Last Name	
Date of Birth / Gender	Insured's Phone	
Insured's Address		

CONTACTS:

Please list the following: If married, spouse information; if patient is a minor add parent(s) and/or guardian information not already listed above. Lastly, please list one emergency contact not living in patient's home.

Name	Address	☐ Guardian ☐ Release medical Info ☐ Use as an Emergency Contact
Relationship to patient	Phone Number / e-Mail	

Name	Address	☐ Guardian ☐ Release medical Info ☐ Use as an Emergency Contact
Relationship to patient	Phone Number / e-Mail	

Name	Address	☐ Guardian ☐ Release medical Info ☐ Use as an Emergency Contact
Relationship to patient	Phone Number / e-Mail	

With my signature below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge. I understand if any information changes, it is my responsibility to notify Affleck, M.D. Eye Care.

SIGN HERE

Patient's Signature (*If patient is a minor please have Responsibility Party/Guardian sign*) Today's Date

If not the patient, please print the name of who filled out this form: _____

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TO THE PATIENT: *We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policy is important. We offer services to you provided that you understand and comply with the policies of our practice. By signing this form and/or by receiving medical services from Affleck, M.D. Eye Care. ("AEC"), you agree to the following:*

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Patients not using insurance benefits or third party payer will receive a discount for services rendered (some restrictions may apply); when payment is made in full at the time services are rendered. Discount does not apply for vision services charges or products.
You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed.

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier and any small remaining balance under $35.00 will remain on your account as a credit for your next visit. Large balances will be returned to the payer. If you want all remaining balance returned, please request in person or in writing. Allow 2 weeks for refund.

You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim which can take up to 60 days. Idaho and Federal laws prohibit waiving full or even partial co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Therefore, we cannot waive declared "patient's responsibility" amounts. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact us to address the problem or to discuss a workable solution.

The balance of any account not paid within thirty (30) days will begin to accrue interest at the rate of or 1.5% per month (18% APR), or the maximum allowed by applicable law, whichever is higher. Part payment while appreciated will not stop interest and additional fees from accruing. Nor will it stop the account being sent to collections. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency and your doctor-patient relationship will be terminated. Other patients for which you are financially responsible, including a member of your family, dependent, someone living in your same home, or on any account for which you are a Financial Responsible Party with also have their doctor-patient relationship terminated. A re-billing processing statement fee of $10.00 will be charged to your account each month after the initial statement. For small balances, between $0.01 to $10.00, we may stop sending billing statements any time after the initial statement, but you understand that the amount shall remain due and owing until paid in full.
Over Due Balances. All balances over 30 days must be paid in full before scheduling the next appointment.

A payment plan must be in writing and arranged BEFORE YOUR BALANCE IS DUE. Approval must be made directly with the manager. A credit card must be placed on file and authorized for payment. A monthly payment of 25% of the balance is required. Once a monthly payment is missed the card will be charged the unpaid balance along with any interest and billing processing fee. The payment plan only applies to past balance. All new appointments must be paid in full before rendering services. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover) and Care Credit (some restrictions apply).

PAYMENT BY CHECK: If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $20.00 or up to the applicable state maximum legal limits, whichever is higher, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize AEC, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax).

PLEASE NOTE: The above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee.

MANAGED CARE (HMO, PPO, ETC.) If you request an office visit without a required referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

THIS DOCUMENT CONTINUES ON THE BACK OF THIS PAGE↺

MEDICARE. AEC is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. Medicare submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information to them.

MEDICAID. If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified monthly. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

WORKERS' COMPENSATION CASES. Charges for services incurred as a result of a verified work related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

THIRD PARTY LIABILITY INJURIES. If you receive treatment as a result of a third party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because AEC does not protect charges incurred relating to or arising out of third party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments. AEC cannot act as administrator to resolve financial arrangements. We will collect information about your personal medical insurance in case the auto/third-party carrier denies your claim, as the patient, you are ultimately responsible for payment.

ADDITIONAL CHARGES. Patients may incur and are responsible for the payment of additional charges at the discretion of AEC including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law. You directly may be charged $45 for missing your scheduled appointment altogether or for cancelling/ rescheduling after 10 A.M. the prior business day before your scheduled appointment. For Monday appointments, you must contact us by 10 A.M. the prior Friday. For Wednesday appointments you must contact us by 10 A.M. the prior Monday.
You (not your insurance) may be charged a minimum of $45 up to the maximum allowed if we must reschedule your exam on the day of your appointment due to excessive lateness (over 15 minutes late), not having an insurance required referral/pre-authorization, or unable to pay co-pay or balance. If you no show three appointments within a 12 month period of time, you will be placed on our same day appointment track or terminated.

NON-PAYMENT ON ACCOUNT. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that AEC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record.

MINOR PATIENTS. The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of AEC. Regardless of custody arrangements or divorce decrees, you agree the person bringing a dependent in for services is responsible for all copayments, etc., and is expected to pay at the time service is rendered.

FINANCIAL POLICIES NOTIFICATION

I acknowledge and agree to the FINANCIAL POLICIES of AEC. You may view the current version online at www.LovehealthyEyes.com or request a copy from the staff. These policies may be changed from time to time by AEC, without notice.

THIS DOCUMENT CONTINUES ON ANOTHER PAGE

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Affleck, M.D. Eye Care ("AEC") appreciates the confidence you have shown in choosing us to provide for your health care needs. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s)

PRACTICE CONSENT

CONSENT FOR TREATMENT:

I (or the patient's authorized representative) consent to health care, including but not limited to examinations, test, procedures, diagnosis, medical management, and/or surgical treatment by Aaron J. Affleck, M.D. or his staff. I understand that health care is not an exact science; it may have a risk of injury which will be explained to me. I acknowledge there is no guarantee of my diagnosis(s), examination(s) or treatment(s) results. I understand payment of services rendered must be paid and are my responsibility independent of results or the time between services rendered and notice of bill. I understand that if I do not consent to the recommended treatment, I may endanger my vision, life, or health.

INFORMATION REGARDING DILATING EYE DROPS:

Dilating drops enlarge the pupils of the eye to allow Dr. Affleck a better view of the inside of your eye. Dilating drops may blur vision and/or cause sensitivity to light and impair driving. After the exam please make arrangements not to drive. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

CONSENT FOR THE USE OF DILATING EYE DROPS:

I (or the patient's authorized representative) hereby authorize Aaron J. Affleck, M.D. and/or staff to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

PRESCRIPTION HISTORY CONSENT:

I voluntarily consent to provide AEC access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by Dr. Affleck, M.D. and his staff, and it may include prescriptions dating back for several years. I acknowledge that AEC may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

AUTHORIZATION TO CONTACT:

I (or the patient's authorized representative) authorize AEC personnel or any agent or servicer to communicate by mail, answering machine messages, text, and/or e-mail according to the information provided in my patient registration information. I understand some methods of communication may be unsecure. The communication will be related to my account, treatment or services, including but not limited to appointment reminders, debt collection, post-procedure instructions, follow-up instructions, educational information, purchase status, services/product offers and prescription information. I expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if I am charged for the contact. I agree to advise AEC if my mobile number changes or if this is no longer in my possession. Note: You may opt out of these communications at any time.

INSURANCE APPLICATION AND ASSIGNMENT OF BENEFITS CONSENT:

Without waiving any obligation to pay, I (or the patient's authorized representative) assign to AEC, for application onto my bill for services, all of my rights and claims for the medical benefits to which I, or my dependents are entitled, under any healthcare plan (including, but not limited to, Medicare or Medicaid), commercial policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. If any payment is made directly to me for services billed by AEC, I agree to promptly submit same to AEC until my patient account is paid in full. I (or the patient's authorized representative) authorize AEC and associated physicians, staff, and hospitals to release patient information acquired in the course of my exam and/or treatment including but not limited to any and all medical records, notes, test results, or other documents related to my treatment that is deemed necessary to process claims. INSURANCE INFORMATION:
I (or the patient's authorized representative) am responsible to keep insurance information current and correct at AEC and am responsible for the balance of unpaid claims due to inaccurate information.

AGREEMENT OF PAYMENT:

I (the Insured/Guardian/Patient) am ultimately responsible for all payment obligations and guarantee payment. Whether or not I have insurance or are self-pay, I will pay my balance in full within thirty (30) days of receipt of my billing statement to: ***Affleck, MD Eye Care, P.O. Box 30015 Department #224, Salt Lake City, UT 84130.*** If I make a payment that results in a surplus on my account, I authorize AEC to apply the overpayment to any other account for which I am financially responsible, including my account, a member of my family's or dependent's account, or on any account for which I am a Financial Responsible Party.

THIS DOCUMENT CONTINUES ON THE BACK OF THIS PAGE↺

PATIENT: _____ DOB: _____

INSURANCE CLAIMS:

As a curtesy AEC may submit insurance information to my insurance company for processing. I (the Insured/Guardian/Patient) am responsible to pay all charges before my insurance company pays or determines the amount I owe regardless of any billing mistakes, disputes or denials.

PAYMENT AT TIME OF SERVICE:

I (the Insured/Guardian/Patient) agree that in return for the services, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to AEC for payment by my insurance company/third-party payor. I agree to pay any co-payment, non-covered services, co-insurance, deductibles or any other patient responsibility due at the time of service. I may also receive a bill for any amounts due that are not collected at time of service.

BENEFIT INFORMATION:

I (the insured/guardian/patient) am responsible for knowing my insurance policy, facilitate payment of claims and disputing any denials. I am to ensure my insurance company pays and I am responsible for satisfying any conditions necessary for insurance or health benefits and not Affleck, MD eye care.

I am to personally inquire from my insurance company information including but not limited to referrals, pre- authorization, in-network benefits and second option requirements. AEC cannot guarantee quotes given either verbally or written by staff or Dr. Affleck, I guarantee payment including in these common situations:
my health plan determines that the services are not medically necessary and/or not covered my health plan coverage has lapsed or expired I have chosen not to use my health plan coverage.

Dr. Affleck may be out-of-network with you vision insurance but not your medical. Many times they reimburse you more than us.
When services of procedures and/or surgeries are performed, Dr. Affleck follows standard of care and what is in the best interest of the patient's care. This means visits for care are based of patient's healing process and may take longer than dictated global periods. When using a third party payer (insurance company, vision plans and etc.) as an in-network provider, we agree to follow their rules and payment requirements. Insurances dictate charge amounts, charge timeline, and definition of complications.

Patients will be responsible for additional charges out-side of global periods and conditions that develop after the procedure which are not defined as a bundled surgery cost. With surgery treatment, you may possibly receive up to three bills for the treatment. You will receive charges from Aaron J. Affleck, M.D., the surgical facility, and anesthesia. You are responsible to understand your out-of-pocket costs from all health care resources. We are not responsible for any charges or billing practices from the surgical facility, anesthesiologist or healthcare personnel that are not part of Affleck, MD Eye Care.

MEDICAL/VISION EYE CARE SERVICES

An important aspect of your exam is the refraction assessment. It detects deterioration, checks coordination and indicates the health of your eyes. It is necessary to adequately determine visual function and is important in determining if serious underlying eye problems exist. Tracking results from refraction assessments over time assists Dr. Affleck in determining and managing your care. A REFRACTION ASSESSMENT IS A NON-COVERED SERVICE WITH MOST MEDICAL INSURANCE AND IS NOT COVERED BY MEDICARE. This service is not optional and will be performed with your understanding that you are responsible for the charges.

WHAT IS THE DIFFERENCE BETWEEN A MEDICAL EYE EXAM AND A VISION EXAM?

For insurance purposes, eye examinations are divided into two categories:

VISION EXAM: These exams have many names: routine, preventive, screening or "Wellness Vision" exams for people who have no eye disease or symptoms of disease but may need glasses or contact lenses. These exams do not allow any treatment. If Dr. Affleck finds anything abnormal during your vision exam, further testing of a medical nature may be needed and treatment given. In that case, your medical insurance would be billed.

MEDICAL EXAM: This is a medically necessary comprehensive examination for the diagnosis and treatment of diseases and conditions of the eye. This exam evaluates the reasons for the symptoms and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases.

SIGNATURE PAGE FOR

"PRACTICE CONSENT," "MEDICAL/VISION EYE CARE SERVICES", "PATIENT FINANCIAL RESPONSIBILITY STATEMENT" and "NOTICE OF PRIVACY PRACTICES" by signing below, each of the undersigned acknowledges that: I have been provided a copy of the Affleck, M.D. Eye Care" "practice consent," "medical/vision eye care services" and "patient financial responsibility statement." I have read, understand, asked any questions and agree to their provisions and agree to the specified terms. Further agree that a photocopy of this "practice consent," "medical/vision eye care services" and "patient financial responsibility statement" shall be as valid as the original. Once I have signed this agreement, whether by original, facsimile or electronic (".PDF") signature, I agree to all of the terms and conditions contained herein and the agreement shall be in full force and effect.

Notice of privacy practices: The complete document that states Affleck, M.D. Eye Care's privacy practices is posted for you to read in full or a flyer is available. You can also read it on our website at www.loveheathyeyes.com. All new patients please read it carefully. It explains our commitment to maintaining the privacy of your private health care information. I you would like a copy we will provide it to you. By signing below, you are acknowledging that you have received a copy of Affleck, M.D. Eye Care's notice of privacy practices or one has been offered to you.

SIGN HERE

Patient's Signature (*If patient is a minor please have Responsibility Party/Guardian sign*) Today's Date

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Please type or print clearly and use additional paper if you need more space. Bring this completed form to your appointment.

Patient Name: _____ Birth Date: _____ Weight: _____

Last Eye Exam: _____ By who: _____ Height: _____

The reason for your visit today? _____

CURRENT eye symptoms? ☐ Check here if none

☐ Decreased vision	☐ Eye lid bumps	☐ Foreign body sensation	☐ Loss of side vision
☐ Double vision	☐ Eye pain	☐ Glare, halos around lights	☐ Red Eye
☐ Dry eye	☐ Flashing lights/ floaters	☐ Itching or burning eyes	☐ Tearing/ discharge

Other: _____

Prior Eye Problems (*mark all that apply*) ☐Check here if none

☐Amblyopia(lazy eye)	☐Crossing eyes	☐Glaucoma	☐Keratoconus	☐Optic neuritis
☐Astigmatism	☐Diabetic retinopathy	☐Hyperopia (far sighted)	☐Macular degeneration	☐Retinal Detachment
☐Cataracts	☐Dry eyes	☐Iritis/Uveitis	☐Myopia (near sighted)	☐Serious eye injury
☐Other: _____			☐Worn an eye patch as a child	

If you have glaucoma: ☐Check here if no glaucoma diagnosed Year diagnosed? _____

Month & year of your last visual field test? _____ Previous eye care provider _____

✎ Please bring to your appointment a list of MEDICATIONS with DOSAGES.

List allergies to any medications: _____

Which artificial tears do you use? ☐ None _____ How often do you use them? _____

List any eye surgeries: ☐Check here if no eye surgeries

Type of Eye Surgery:	Which Eye:	Year:

List non-surgery hospitalization: ☐Check here if no hospitalization

Month & Year:	Reason:

Medical History (*mark all that apply*) ☐Check here if no medical history

☐ AIDS/HIV	☐ Cancer	☐ Herpes	☐ Stroke	☐ Graves Disease	☐ Anesthesia issues	☐ Steroid Use
☐ Arthritis	☐ Dementia	☐ Lupus	☐ Hypertension	☐ Heart disease	☐ Thyroid disease	
☐ Asthma	☐ Diabetes	☐ Migraine	☐ Hypothyroidism	☐ Seasonal Allergies	☐ Multiple Sclerosis	

THIS FORM CONTINUES ON THE BACK OF THIS PAGE↺

PATIENT: _____ DOB: _____

Immediate Family History (*check all that apply*) Please note relation to yourself using F-Father, M-Mother, S-Sister, B-Brother (example : Diabetes-F or Glaucoma-S/B)					
☐ Arthritis		☐ Hypertension		☐ Macular Degeneration	
☐ Diabetes		☐ Heart Disease		☐ Retinal detachment	
☐ Blindness		☐ Thyroid Disease		☐ Crossed/ Lazy Eye	
☐ Cataract		☐ Glaucoma		☐ Stroke	

Do you use? ☐Tobacco ☐Alcohol ☐Recreational Drugs

Do you wear any corrective lenses? ☐ No ☐ Yes, if yes (mark all that apply) ☐ Glasses ☐Reading Glasses ☐ Hard Contacts lenses ☐ Rigid Gas lenses ☐ Soft Contact lenses

Has your eyeglass prescription ever had prism in it? ☐ No ☐ Yes
Are new eyeglass prescriptions easy to adjust to? ☐ No ☐ Yes
Do you have a hard time focusing on objects? ☐ No ☐ Yes
Are you interested in LASIK? ☐ No ☐ Yes

Does your vision limit daily activities? ☐No ☐Yes – When? ☐Driving ☐Sports ☐Work ☐Other: _____

Are you light sensitive? ☐ No ☐ Yes – When? ☐ Always ☐ At Night ☐ Looking at head or street light
☐ Other: _____

Do you have problems with reading? ☐ No ☐ Yes – How? ☐ I quickly feel tired ☐ I tear a lot ☐ I need more light to read
☐ Other: _____

Has your vision decreased? ☐ No ☐ Yes – How? ☐ Gradual ☐ Sudden ☐ Temporary ☐ Permanent

Do you experience frequent head or forehead pain? ☐ No ☐ Yes
Do you experience frequent neck pain? ☐ No ☐ Yes
Do you frequently lift your eye brows to see better? ☐ No ☐ Yes
Do you frequently lift your chin to see better? ☐ No ☐ Yes
Are you interested in removing loose eyelid skin? ☐ No ☐ Yes