JAMES EYECARE
& OPTICS GALLERY

Name: _____ Date: _____
Cell Phone: _____
Home Phone: _____
Email: _____
Preferred Language: _____

Vision Plan: _____
Medical Insurance: _____
PCP Name: _____
PCP Number: _____
Pharmacy: _____

Race:
◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian or other Pacific Islander ◯ White ◯ Other

Ethnicity:
◯ Hispanic or Latino
◯ Non-Hispanic or Latino

Please update your medical history to reflect changes in the last two years, or since your last visit:

Current Medications (Rx or OTC):

_____
_____
_____
_____

Allergies to medications? ◯ Yes ◯ No

If so, what medications? _____
_____
_____
_____

Have you had any surgeries? ◯ Yes ◯ No

Please List: _____
_____
_____

Please Circle:

Tobacco? No / Smokeless / _____ packs per day/week

◯ Never Smoker ◯ Former Smoker
◯ Occasional Smoker ◯ Current Smoker

Alcohol? None / Rarely / Monthly / Weekly / Daily

Do you currently have any problems in the following areas:

	Yes	No	Explanation of Problem:
Allergies	◯	◯	_____
Arthritis	◯	◯	_____
Blood/Lymphatic	◯	◯	_____
Cancer	◯	◯	_____
Cholesterol	◯	◯	_____
Diabetes	◯	◯	_____
Digestive	◯	◯	_____
Ears/Nose/Throat	◯	◯	_____
Endocrine	◯	◯	_____
Eczema/Rashes	◯	◯	_____
Genital-urinary	◯	◯	_____

	Yes	No	Explanation of Problem:
High Blood Pressure	◯	◯	_____
Integumentary (Skin)	◯	◯	_____
Kidney	◯	◯	_____
Muscle/Bone	◯	◯	_____
Neurological	◯	◯	_____
Psychological	◯	◯	_____
Respiratory	◯	◯	_____
Sinus	◯	◯	_____
Thyroid	◯	◯	_____
Unusual Weight Loss/Gain	◯	◯	_____

Do any of the following run in your family?

	Yes	No	Relationship to Patient:
Blindness	◯	◯	_____
Cataracts	◯	◯	_____
Corneal Problems	◯	◯	_____
Glaucoma	◯	◯	_____
Lazy Eye	◯	◯	_____
Macular Degeneration	◯	◯	_____
Retinal Problems	◯	◯	_____
Arthritis	◯	◯	_____

	Yes	No	Relationship to Patient:
Cancer	◯	◯	_____
Diabetes	◯	◯	_____
Heart Disease	◯	◯	_____
High Blood Pressure	◯	◯	_____
Kidney Disease	◯	◯	_____
Lupus	◯	◯	_____
Thyroid Disease	◯	◯	_____
Other	◯	◯	_____

JAMES EYECARE & OPTICS GALLERY | Look Forward

INSURANCE • FINANCIAL POLICY • WARRANTY • HIPAA

IMPORTANT BILLING INFORMATION: Medical Insurance vs. Vision Plans

The type of eye exam you have is determined by the reason for your visit, or your chief complaint, as well as your diagnosis. Most insurance companies focus on the reason for your visit.

Your Vision Plan (VSP, EyeMed, VCP, etc.) will be billed when your eye exam is routine in nature. This exam usually produces a final diagnosis such as nearsightedness, farsightedness, and/or astigmatism.

Your Medical Insurance Plan will be billed when the focus of your eye exam is medical in nature. Typically this exam produces a final diagnosis such as conjunctivitis, cataracts, glaucoma, etc.

_____ **I agree to this policy** (patient or responsible party's initials)

CONTACT LENS EVALUATIONS

Contact lens wearers require a separate prescription, and are at greater risk for infection and corneal tissue damage. Therefore, a proper evaluation is essential. The fee for the evaluation ranges from $18-$89 for existing wearers and $61-$127 for new wearers. This fee covers necessary trial contact lenses and follow up appointments for 90 days.

_____ **I agree to this policy** (patient or responsible party's initials)

WARRANTY

Patient and customer satisfaction is very important to us, so we provide the following:

- Two-year warranty on all eyeware – if anything should happen to your frames, we will be happy to repair or replace them at no cost to you. (Does not cover loss or theft.)
- Satisfaction guarantee on all contacts – if you are ever dissatisfied with the comfort or performance of your contacts, or your prescription changes mid-year, we will be happy to exchange your remaining supply.

Additionally, we offer discounts and rebates on year supplies of contacts as well as 2nd pair savings, and vision plan discounts on eyeware.

If you're interested in LASIK (Laser Vision Correction) be sure to ask your technician for a complimentary evaluation to see if you are a good candidate for the surgery.

HIPAA and OFFICE POLICIES

You have the right to review our notice of privacy practices [Health Insurance Portability & Accountability Act of 1996], as well as a comprehensive listing of our office policies and billing procedures. You may obtain a current copy of your notice of privacy practices and our policies at any time by request.

All payments, including co-pays, are due at the time services are rendered.

_____ **I agree to this policy** (patient or responsible party's initials)

Our office has implemented a particular EHR (Electronic Health Records) which now allows you to have online access to your PHR (Personal Health Record). If interested in this feature please ask us!

Patient / Responsible Party's Signature: _____ Date: _____