JAMES EYECARE & OPTICS GALLERY | Look Forward

Welcome to our office!

PATIENT INFORMATION

Date: _____

Name: _____

Street: _____

City: _____

State: _____ Zip Code: _____

Cell Phone: (_____) _____

Home Phone: (_____) _____

Daytime Phone: (_____) _____

Email: _____

Date of Birth: _____ Age: _____

Patient's SSN: _____

Sex: ◯ M ◯ F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

PCP Name: _____

PCP Number: _____

Pharmacy: _____

Preferred Language: _____

Race:

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

Ethnicity:

◯ Hispanic or Latino ◯ Non-Hispanic or Latino

How did you hear about us?

◯ Friend or Relative: Who? _____
◯ Magazine Ad: Which? _____
◯ Another Doctor ◯ Insurance List
◯ Sign/Building ◯ Website
◯ Social Media ◯ Other: _____

INSURANCE • PREFERRED PAYMENT

Vision Plan: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

Primary Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

How would you like to provide payment today?

◯ Cash ◯ Check or Debit Card ◯ Credit Card
◯ Flexible Spending Account ◯ Care Credit

PATIENT EYE HISTORY

Date of last eye exam: _____

Do you currently wear contact lenses? ◯ Yes ◯ No

If so, what kind? _____

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

Are you satisfied with the vision and comfort of your current glasses? ◯ Yes ◯ No

Would you like to know if you are a good candidate for LASIK (Laser Vision Correction)? ◯ Yes ◯ No

Have you ever experienced, been diagnosed with, or been treated for any of the following?

◯ Cataracts ◯ Dry Eyes
◯ Crossed Eye/Eye Turn ◯ Iritis/Uveitis
◯ Double Vision ◯ Lazy Eye
◯ Eye Injury ◯ Macular Degeneration
◯ Floaters/Spots in Vision ◯ Retinal Detachment
◯ Glaucoma ◯ Other Eye Disorders:

_____

OUR MISSION

James Eyecare & Optics Gallery is dedicated to providing the highest quality in patient care and unsurpassed customer service. We're proud to offer one of the largest selections of quality, fashion forward frames and sunglasses coupled with the latest in lens technology and superior lenses. Our staff truly cares about the health of your eyes and your experience in our office.

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

PATIENT MEDICAL HISTORY

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

FAMILY HISTORY

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	◯	◯	_____
Cancer	◯	◯	_____
Diabetes	◯	◯	_____
Heart Disease	◯	◯	_____
High Blood Pressure	◯	◯	_____
Kidney Disease	◯	◯	_____
Lupus	◯	◯	_____
Thyroid Disease	◯	◯	_____
Other	◯	◯	_____

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	◯	◯	_____
High Blood Pressure	◯	◯	_____
Integumentary (Skin)	◯	◯	_____
Kidney	◯	◯	_____
Muscle/Bone	◯	◯	_____
Neurological	◯	◯	_____
Psychological	◯	◯	_____
Respiratory	◯	◯	_____
Sinus	◯	◯	_____
Thyroid	◯	◯	_____
Unusual Weight Loss/Gain	◯	◯	_____

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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: _____