PATIENT INFORMATION

Date_____

First Name _____
Middle Name_____
Last Name _____
Address _____
_____
_____
city state zip
sex ( ) M ( ) F age_____ Birth date _____
( )single ( )married ( )divorced ( )widowed

Patient SS# _____
Occupation_____
Employer_____
Employer address_____
_____
_____
Employer phone_____
Who referred you to our office?
_____

INSURANCE INFORMATION

Who is responsible for payment on this account?
_____
Relationship to patient_____

Primary Insurer_____
ID # _____
Group # _____
Policy holder_____
Relationship to patient_____
Policy holder Date of Birth_____
Policy holder SS# _____

Secondary insurer_____
ID# _____ Group_____
Policy holder_____
Relationship to patient_____
Policy holder Date of Birth_____
Policy holder SS# _____

ALL INFORMATION ABOVE IS NEEDED TO PROPERLY SUBMIT YOUR CLAIM. YOU WILL BE ASKED TO PRESENT A MASTERCARD OR VISA AND A DRIVER'S LICENSE FOR IDENTIFICATION AND GUARANTEE OF PAYMENT.

CONTACT INFORMATION

Telephone numbers Home_____ Work_____

Cell phone_____
I prefer to be called at ( )home ( )work ( )cell

Email address_____

Whom can we contact in an emergency
Name_____Relationship_____
Phone number_____

Primary care physician: _____Last Physical_____
Address of physician_____
_____Phone_____Fax_____

Would you like more information about any of the following?

( )contact lenses	( )vision therapy	( )other_____
( )corneal refractive therapy	( )new eyeglass frame styles	_____
( )laser eye surgery	( )ultrathin eyeglass lenses	_____
( )tinted contact lenses	( )sports vision	

EYE HEALTH HISTORY

Todays visit is for a ( )medical eye problem ( )vision problem ( )routine check up
Reason for visit today_____
Date of last eye examination_____Name of Doctor_____
Do you wear eyeglasses? ( )Y ( )N ( )full time ( )distance vision ( )near vision ( )occasionally ( )other_____
Do you wear contact lenses? ( )Y ( )N ( )Hard ( )Soft ( )Full time ( )occasionally
Are you currently pregnant or nursing an infant ( )Yes ( )No
Are you a smoker ( )Y ( )N packs per day_____ Alcohol consumption_____

Please check any of the symptoms you currently have.

( )Bloodshot eyes
( )Blurred vision- distance
( )Blurred vision- near
( )Burning eyes
( )Chronic fever
( )Crossed or wandering eyes
( )Discharge from eyes
( )Dizziness, fainting, blackouts
( )Double vision
( )Dry eyes
( )Eye injury
( )Eye pain
( )Eye strain
( )Floaters or spots
( )Headaches
( )Itching eyes
( )Light flashes
( )Light sensitivity
( )Loss of vision
( )Poor night vision
( )Red eyes
( )Seeing haloes around lights
( )Temporary loss of vision
( )Twitching eyelid
( )Watering eyes
( )Weight loss/gain

allergies:

_____
_____
_____
_____

Please check any of the problems you or a family member has had.

You	Family	
( )	( )	Blindness
( )	( )	Cancer
( )	( )	Cataracts
( )	( )	Crossed eyes
( )	( )	Eye infection
( )	( )	Eye injury
( )	( )	Eye surgery
( )	( )	Glaucoma
( )	( )	Lazy eye
( )	( )	Migraines
( )	( )	Poor color vision
( )	( )	Retinal problems
( )	( )	Wandering eye

List current medications and what they are used for

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check any of the conditions that apply to you or your family

You	Family	
( )	( )	**Cardiovascular** *(Heart, HBP, stroke)*
( )	( )	**Respiratory** *(Asthma, emphysema, TB)*
( )	( )	**Gastrointestinal** *(colitis, Inflamm. Bowel*
( )	( )	**Endocrine** *(Diabetes, thyroid)*
( )	( )	**Immunological** *(AIDs, HIV, lupus, Sjogrens, arthritis, sarcoid, MS)*
( )	( )	**Urological** (kidney, prostate)
( )	( )	**Dermatological** *(rashes, dermatitis)*
( )	( )	**Musculoskelatal** *(joint, muscle pain, arthritis)*
( )	( )	**Neurological** *(epilepsy, paralysis)*
( )	( )	**Psychiatric** *(depression, anxiety, ADD)*
( )	( )	**Hepatic** *(liver disease, Hepatitis)*
( )	( )	**Blood diseases** *(sickle cell, bleeding)*
( )	( )	**Ear/Nose/Throat**
( )	( )	**Other**

_____

For pediatric patients:

( ) Full term birth
( ) Premature _____ weeks
Crawled at _____months
Walked at _____months
Spoke words at _____ months

Past or current treatment:
( ) Occupational Therapy
( ) Physical Therapy
( )Speech Therapy

Grade in school _____
Reading on level y n
Math on level y n
Past retention y n

Payment Policy

Payment in full is expected for all services when they are rendered. Payment in full is expected before any materials can be ordered. Copayments for materials under vision plans are due in full before materials can be ordered. Any warranties on materials take effect at the time they are ordered. It is the patient's responsibility to pick up materials in a timely fashion and to return any materials before the warranty on these materials has expired. Should you cancel an order for materials after it has been placed you will be responsible for any charges that we have incurred. A late fee of 1% per month of the balance due will be charged to your account for all accounts more than 30 days past due. **For accounts over 60 days past due: We reserve the right to automatically bill your credit card for any of these charges on your account unless other arrangements have been made.** Account balances not billed to credit cards will be either turned over for collection or sent to small claims court. Any collection fees will be charged to your account as well.

Patients with insurance: Vision care insurance will typically cover routine vision care that is non-medical in nature. Medical insurance will typically cover medically related services. Some medical plans will allow annual or biannual routine exams. Your responsibility is as follows:

1. To present a valid insurance card at the time of your visit.
2. To identify whether your visit is routine or for a medical vision or eye problem. Your insurance company may require different testing documentation for different kinds of visits.
3. If you are coming in for a routine visit you must check with your insurance company to determine if you are currently eligible for routine vision care. If you are not eligible, you will be responsible for the full office visit charges at the time of your visit.
4. If your visit is for a medical eye or vision problem you must check whether your insurance requires you to present a referral for specialist visits. We are considered a specialist by all medical insurance plans. You are responsible for having this referral at the time of your visit so that we may submit the claim to your insurance for reimbursement. Should you not have the necessary paperwork at the time of your visit, you will be responsible for payment at the time of service, and for submitting the needed forms to your insurance company.
5. If you are coming in for a medical eye or vision problem your insurance company will only reimburse us for the medical portion of the testing. You will be billed separately for the refraction and any other part of the eye examination that is not covered. This fee will be collected at the time of your visit.
6. We submit all insurance forms electronically for payment within one day of the date of service. Any claims that have been verified as being received by your insurance company but not settled after 60 days will be transferred to the patient for payment. It is then your responsibility to follow up with your insurance company.
7. All applicable copayments, deductibles, or non-covered items (services and materials) must be paid for at the time of your visit. These are fees that your insurance company withholds from us and insists that we collect from you. Your insurance company makes no guarantee of payment even when they have given us authorization for services or materials, or when they have certified eligibility. You will be billed for any services or materials that are applicable following our receipt of an explanation of benefits from your insurance company

Medicare patients:

Medicare will pay 80% of the medical part of your examination today. This takes effect only after you have reached your deductible for the year. You are responsible for the balance of 20% unless this is covered by secondary or Medigap insurance. If Medicare has your secondary insurer on file, the claim will be automatically sent to your secondary insurer. If there is no secondary insurer on file with Medicare it is your responsibility to submit the 20% copayment to your secondary insurer. You will be responsible for the refraction charge at the time of visit, as this is not covered by either Medicare or Medigap policies.

I have read and understand and agree to the above policies on this day _____.

♦I hereby give Dr. Rothman authorization to submit claims to my insurance carrier for any services provided to me by Dr. Rothman. I authorize the release of medical or any other information about me necessary to process any of the aforementioned claims.

♦I understand and agree that in accepting treatment from Dr. Rothman, I am ultimately responsible for all fees which occur as a result of care rendered to me or my child, regardless of whether they are covered by insurance.

♦I agree to have my credit card on file used to clear any past due balances over 60 days old. *_____ (initial here)

♦I acknowledge receipt of any contact lens prescription that has been finalized after my visit.

♦I have been given an opportunity to review the privacy policies of this office and

□ **I do not wish to at this time** □ **I would like a copy of the policies**

_____ _____

Name of person responsible for account Signature