ESPY VISION

Welcome Form

PATIENT INFORMATION

Title ______ Name (Last, First, MI) ____

Address ____ City ______________ State ________ Zip __________

Phone ( )______________ Birth Date (MM/DD/YYYY) ____/____/______ Sex _____ ☐ Married ☐Single ☐Widowed ☐Student

Email _______________________________________ Occupation ____________________________________

In case of emergency, contact ____________________ Relationship ______________ Phone ( ) ______________

How did you hear about our office? ☐ Walk-In ☐ Billboard ☐ Online ☐ Referred by ______________________________

Do we have your permission to communicate by email/text? (Appt reminders, statements, etc) ☐ Yes ☐ No

What is the reason for your visit today: ☐ Routine exam (Rx updates only) ☐ Medical exam (Red eye, flashes, vision loss, etc.)

INSURANCE INFORMATION

Vision Insurance: ______________________________

Group# ___________ ID# ____________________

Subscriber Name ______________________________

DOB _________ Subscriber SS # __________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance: ______________________________

Group# ___________ ID# ____________________

Subscriber Name ______________________________

DOB _________ Subscriber SS # __________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

EYEWEAR HISTORY

Date of last eye exam:____________________ Were you dilated? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No ☐Full Time ☐ Part Time ☐ Distance ☐ Reading ☐ Bifocals/Progressive

Do you wear contact lenses? ☐ Yes ☐ No Hours worn per day? ___________ Overnight wear: ☐ Yes ☐ No

Brand of Contacts: __________________________ Brand of cleaning solution used: __________________________

How frequently do you replace your contacts? Every _________ ☐ day/s ☐ weeks ☐ months Age of this pair: _____________

Do you use eye drops? ☐ Yes ☐ No (please list) ____

History of eye injuries/surgeries? ☐ Yes ☐ No (*please list*) ____

Any history of eye diseases? ☐ None ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Lazy Eye ☐ Retinal Detachment ☐ Other (*please list*)

Contact Lens Fitting Policy

The contact lens fitting fee includes all necessary follow-up visits within 60 days of the initial fitting date. I understand that I will be charged an additional $25 for each office visit if I do not return for required visits within the allowed 60-day period to finalize my contact lens prescription. *I understand that fees for professional services are NON-refundable.*

Signature ____________________ Date ____________________

Medical History

Primary Care Physician: ____________________ Date last seen: ____________________

Do you have/have had any of the following?

□ Yes □ No **Pregnant/Nursing**

□ Yes □ No **Constitutional** (Fever, Sudden Weight Loss/Gain, etc.)

□ Yes □ No **Ears, Nose, Throat** (Sinus trouble, etc)

□ Yes □ No **Neurological** (Migraines, Bell's Palsy, Shingles, etc.)

□ Yes □ No **Respiratory** (Asthma, Emphysema ,etc.)

□ Yes □ No **Psychiatric** (Depression, Drug Dependency, etc.)

□ Yes □ No **Allergic/Immunologic** (Allergies, HIV, etc.)

□ Yes □ No **Genitourinary** (Kidneys, Prostate, Ovaries, STDs, etc.)

□ Yes □ No **Musculoskeletal** (Arthritis, MS, etc.)

□ Yes □ No **Integumentary** (Skin Cancer, New Growths, etc.)

□ Yes □ No **Hematologic/Lymphatic** (Blood Disorders, etc.)

□ Yes □ No **Cardiovascular** (Blood Pressure, Heart Attack, etc.)

□ Yes □ No **Gastrointestinal** (Ulcers, Nausea, etc.)

□ Yes □ No **Endocrine** (Thyroid, Diabetes, etc.) If Diabetic, please note Type 1 or 2, Physician, Blood sugar and A1C value if known. ____________________

Any ***FAMILY*** history of the following conditions? □ None □ High Blood Pressure □ Diabetes □ Heart Condition □ Thyroid □ Arthritis □ Glaucoma □ Macular Degeneration □ Cataracts □ Lazy Eye □ Retinal Detachment □ Other

Any current medications (including oral contraceptives, aspirin or over the counter medications)? □ Yes (*please list*) □ No

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Any drug or medical allergies? □ Yes (*please list*) □ No ____________________

Social history

Do you drink alcohol? □ Yes □ No If yes, how often/much? □ Occasional □ 1/day □ 2-3/day □ 4+/day

Do you smoke? □ Yes □ No If yes, how often/much? □ Occasional □ ½ pack/day □ 1 pack/day □ 1+/day

Hobbies/Interests: ____________________

Would you like to learn more about sports vision therapy (benefits for professional as well as hobby sports)? □ Yes □ No

Dr's Signature____________________ Date____________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above stated companies and assign directly to **Espy Vision, PLLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent or Guardian	Please Print Name	Date

Standard dilated fundus exam

We are committed to maintaining the highest level of care for the early detection and prevention of eye disease. As a result, the **dilated fundus exam is included as part of the comprehensive eye exam**. When the pupils are dilated with drops, we can obtain a better view of the back of the eyes to detect early signs of ocular pathologies. **Side effects may include blurred near and/or distance vision and light sensitivity for 4-6 hours;** for ***most*** patients, driving is not affected. Although rare, some patients may experience adverse or allergic reactions to the drops.

_______ Yes, I would like to be dilated today

_______ No, I decline the dilated exam today

____ ____________________

Patient signature Date

Notice of privacy practices

A copy of the "**Notice of Privacy Practices**" is available by request. I acknowledge that I have been given the opportunity to read **Espy Vision's** Notice of Privacy Practices.

Patient Signature Date

Authorization of health information disclosures

I authorize my medical information to be shared with the following individuals:

_______________________________________ _______________________

Name of Individual Relationship

_______________________________________ _______________________

Patient Signature Date