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New Patient Form

Patient Information

Name _____ Date of Birth ____/____/____

Address _____ Sex *Male* / *Female*

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email _____ SSN _____

Preferred contact method *Cell / Home / Email / Other*_____

Language, Race, Ethnicity _____

Marital Status *Single / Married / Other*_____ Date of Last Eye Exam _____

Occupation/Employer _____*Full-Time / Part-Time*

Emergency Contact _____Relationship _____Phone #_____

Primary Care Physician _____Phone # _____

Insurance Information

Vision Plans

Carrier Name _____

Member ID# _____

Policyholder Information *or* ☐ Self

Name _____

DOB ____/____/____

SSN ____-____-____

Relationship *spouse / guardian / other*_____

Secondary Insurance _____

Member ID# _____

Policyholder same as primary? YES / NO

Name _____

DOB ____/____/____

SSN ____-____-____

Relationship *spouse / guardian / other*_____

Medical Plans

Carrier Name _____

Plan Type *PPO* / *HMO*

Member ID# _____

Policyholder Information *or* ☐ Self

Name _____

DOB ____/____/____

SSN ____-____-____

Relationship *spouse / guardian / other*_____

Secondary Insurance _____

Plan Type *PPO* / *HMO*

Member ID# _____

Policyholder same as primary? YES / NO

Name _____

DOB ____/____/____

SSN ____-____-____

Relationship *spouse / guardian / other*_____

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Health History

Patient Name:_____

Do you currently wear *Glasses* *Contacts* *Both*
Interested in contact lenses? Yes / No

Are you currently experiencing or have experienced of any of the following? (Mark all that apply)

- ☐ Blurry vision *Distance* or *Near*?
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing
- ☐ Eye Infection
- ☐ Eye Pain/Soreness
- ☐ Floaters/Spots in Vision
- ☐ Foreign Body/Gritty Sensation
- ☐ Glare/Halos
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Headaches
- ☐ Itching

Have you or a family member experienced or been treated for any of the following conditions?

Cataracts	Self	Family
Crossed/Lazy Eye	Self	Family
Glaucoma	Self	Family
Macular Degeneration	Self	Family
Retinal Detachment	Self	Family

AIDS/HIV	Self	Family
Allergies	Self	Family
Arthritis	Self	Family
Asthma	Self	Family
Blood/Lymph Disorder	Self	Family
Cancer	Self	Family
Diabetes	Self	Family
Ear/Nose/Throat Conditions	Self	Family
Gastrointestinal Conditions	Self	Family
Heart Disease	Self	Family
High Blood Pressure	Self	Family
High Cholesterol	Self	Family
Kidney Disease	Self	Family
Lupus	Self	Family
Neurological Conditions	Self	Family
Psychiatric Disorder	Self	Family
Seizures	Self	Family
Skin Conditions	Self	Family
Stroke	Self	Family
Thyroid Dysfunction	Self	Family

Pregnant or Nursing? Yes / No
Do you smoke? Yes / No
Have you ever smoked? Yes / No
Eye Surgeries? Yes / No
(Please specify) _____

Height _____
Weight _____

Medication Drug Allergies

_____
_____
_____

Prescription Medication	Dosage	Frequency

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Medical vs. Vision Insurance Disclosure

Many patients have both a vision plan, (example: Eyemed, Spectera, or VSP) and medical insurance, (example: Aetna, BCBS, Cigna, Medicare, or UHC). Vision plans and medical plans are very different in the services they cover, and it is important to understand these differences.

Vision Care Insurance

Vision coverage for routine eye examination is designed to provide an evaluation of the health of the eyes in a healthy patient, who has no particular problems or symptoms, and to determine a prescription for glasses only. This examination is a comprehensive ocular health examination but does not include any test or imaging to diagnose, evaluate, and follow any medical issues. This evaluation does not include a contact lens evaluation, or any fees associated with contact lenses.

Medical Insurance

When a medical condition or a medical diagnosis is present that affects your eyes, such as high blood pressure, high cholesterol, diabetes, dry eyes, (to name a few) or an eye disease or eye problem such as macular degeneration, glaucoma, cataracts, eye infection, or allergies (to name a few), we must file the claim with your medical insurance.

Refraction

The doctor performs a test, called refraction, to get your eyeglass prescription. This is performed when you sit behind the phoropter, looking through it at an eye chart placed at optical infinity, allowing the doctor to move lenses of different strengths in front of your eyes. The test also helps your doctor identify presbyopia, hyperopia, myopia, and astigmatism. The fee for this service is $42.00 and is collected when refraction is performed. This service is considered a non-covered service by Medicare and most secondary insurance plans.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel, we will file those claims for you. In the event we do not accept your medical or vision insurance, we will provide you with an itemized receipt, so that you may file for reimbursement with your insurance company. If you have any questions, please let us know.

I understand the information I have just read about the difference between vision and medical insurance. I authorize Lange Eye Care & Associates to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Patient Printed Name _____

Patient Signature _____ Date _____

To be completed by office:

Medical Insurance: _____
Medical Diagnosis: _____
Potential Out of Pocket Expense: _____
Patient Signature: _____

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Notice of Practice Policies

Consent to Treatment Agreement

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I have read all information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Lange Eye Care & Associates P.A. of any changes in my status or the above information. I also understand that the doctor may need to use diagnostic dilation drops/medical treatments to help evaluate the health of the eye. I hereby give my full consent.

_____ _____

Patient/Guardian Signature Date

Receipt of Notice of Privacy Practices

Lange Eye Care & Associates P.A. follows state and federal privacy laws and guidelines to protect your personal information with the utmost care and respect. A detailed list of all clinic privacy practices is available at the reception desk and can be copied upon request.

I, _____, acknowledge that I have reviewed/received a copy of Lange Eye Care and Associates P.A.'s Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

Notice of Business Relationship

The Lange Eye Institute believes that proper nutrition is an important component of maintaining healthy eyesight. Some of the Optometric Physicians at Lange Eye Care & Associates P.A. have a business relationship, including either an ownership interest or an advisory role, with Fortifeye Vitamins, Inc d/b/a Fortifeye Vitamins. Fortifeye Vitamins is the manufacturer of Fortifeye Complete nutritional supplement and other products that we sell in our offices. We sell and recommend these products because we believe that they are the highest quality available. We want to make sure that you are aware of these relationships before you choose to purchase these products. As the patient, you are free to choose the best product to meet your needs. Our staff would be happy to provide you a copy of the formulation of Fortifeye Complete, if you would like to compare it to other products. By signing this form, you acknowledge that you are aware of the relationship between Lange Eye Care & Associates P.A., its optometric physicians, and these companies.

_____ _____

Patient/Guardian Signature Date

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Notice of Practice Policies

Release of Medical Information Consent

This is to authorize to Lange Eye Institute that the following individuals have my permission to discuss my personal health information (PHI) in connection with the diagnosis, treatment, and financial services rendered.

Individual(s) who may receive information on my behalf:

Name _____ DOB ____/____/____

Relationship to patient _____ Phone (____) ____-____

Name _____ DOB ____/____/____

Relationship to patient _____ Phone (____) ____-____

_____ I do not authorize any persons at this time.

_____ _____

Patient/Guardian Signature Date

Optical Consent

The Lange Eye Institute is a material provider for your vision insurance company. The following information is our refund policy regarding eye wear.

Eye wear is a custom-made product designed by your doctor and eye care professionals, especially tailored to each individual patient's needs. It is our policy that there will be NO REFUNDS OR EXCHANGES ON CUSTOM-MADE EYE WEAR. Please be certain that the eye wear YOU have chosen is what you desire before it is custom made.

We thank you for your patronage.

_____ _____

Patient/Guardian Signature Date