WELCOME TO FAMILY EYE HEALTH OPTOMETRY CENTER

Karen L Peschke, O.D. Coral St Onge, O.D.

Patient Information

Last:_____
First :_____Mid Initial:_____
Street:_____
City /State:_____
Zip Code:_____
HomePhone :_____ _❑ Preferred
Cell Phone:_____ _❑ Preferred
OK to text? ❑ Yes ❑ No
Date of Birth _____Age_____ Sex : M F
Employer (or School):_____
Occupation (or Grade):_____
Spouse (or Parent's) Name:_____
Spouse (or Parent's)Work:_____
Email:_____
What is the major purpose of this visit? _____
_____
Date of Last Eye Exam:_____
Date of Last Dilation_____
By Whom?_____
Do you currently wear glasses? ❑ Yes ❑ No Do you currently wear contact lenses? ❑ Yes ❑ No
If yes, What brand?_____ Solution:_____
Are you interest in being evaluated for contact lenses today?* ❑ Yes ❑ No
Will you be using any Vision or Medical insurance coverage for your visit today? ❑ Yes ❑ No (Skip below)
Vision Insurance:_____
Subscriber Name:_____
Subscriber DOB _____Last 4 SSN: _____
Medical Insurance:_____ ❑ HMO ❑ PPO
Will you be using flex spending today? ❑ Yes ❑ No

NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

❑ Friend/relative/ other DR: _____

If not referred, how did you choose our office?

❑ Insurance List	❑ Google Search
❑ Saw Sign/Building	❑ Yellow Pages
❑ Yelp	❑ Other_____

Lifestyle Questionnaire

Do/Are you……(check box if your answer is yes)

❑..want information on LASIK
❑..work at a computer? How many hours? ____day
❑.. spend time outdoors? How much? __ __Hrs/wk
❑..bothered with glare while driving at night?
❑..have family members in need of eye care?

Patient / Family Eye History

Are you experiencing any of the following symptoms?

❑ Blurry Vision	❑ Itchiness
❑ Burning	❑ Grittiness
❑ Double Vision	❑ Sunlight Sensitivity
❑ Flash of light	❑ Tearing
❑ Floaters/Spots	❑ Trouble seeing at night

Have you ever been diagnosed with any of the following?

❑ Cataracts	❑ Iritis/ Uveitis
❑ Corneal Abrasions	❑ Macular Degeneration
❑ Crossed eye/Lazy eye	❑ Retinal Detachment
❑ Glaucoma	❑ Other eye disorders

Any Eye Injury/ Surgery/LASIK?_____

Family History of any eye conditions?_____

Patient Medical History

Name Of Physician:_____
Date of Last check Up:_____
CURRENT MEDICATIONS ((List name of medications including eye drops, vitamins, & birth control pills) :
_____
_____
Do you use cigarettes/tobacco? ❑ Yes ❑ No
Women Only- Are you pregnant or nursing? ❑ Yes ❑ No
Have you ever been diagnosed with any of the following:

❑ Allergies; What kind? _____
❑ Cardiovascular (Arteriosclerosis, Heart murmur)
❑ High Blood Pressure
❑ High Cholesterol
❑ Constitutional (Fevers, Fatigue, Cough)
❑ Head (Headaches, Sinusitis, Dry mouth)
❑ Endocrine (Thyroid, Kidney)
❑ Diabetes; Insulin/ Non-Insulin?_____
❑ Digestive (Acid Reflux, Cirrhosis, Colon/liver cancer)
❑ Genitourinary (Prostate, Uterine, Kidney Stones)
❑ Blood/Lymph (Anemia, Leukemia, Sickle cell)
❑ Immunologic (AIDS, HIV, Herpes Simplex, Syphilis)
❑ Skin (Acne, Basal Cell, dry skin, Psoriasis)
❑ Muscle/Bone (Arthritis, Osteoporosis, Fibromyalgia)
❑ Neurological (Bell's Palsy, MS, Epilepsy)
❑ Psychological (Attn Deficit, Depression, Anxiety)
❑ Respiratory (Asthma, Bronchitis, Lung Disease)

Family History of any of the above conditions?_____
_____

Thank you for selecting Family Eye Health Optometry Center for your Vision Needs!

Cancellation/ No Show Policy

We understand that there are times when you may miss an appointment due to unexpected emergencies. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. If an appointment is not canceled at least 24 hours in advance, you will be charged a $25 fee; this will not be covered by your insurance. I have read and understand the cancellation fee:

Signature X ____ _____ Date_____

Refraction

A refraction is performed as part of your comprehensive eye examination and involves measuring the degree of your refractive error to obtain an updated glasses prescription. If your eyeglasses are purchased at our office, you have 90 days following your Comprehensive Eye Exam to return for a follow- up refraction at no charge. After 90 days, a $45 Refraction fee will apply for any additional glasses refraction if there is a problem with your glasses. If your glasses are purchased outside of our office, you may return within 30 days for a follow-up refraction at no charge. A Comprehensive Eye Examination and health evaluation is required after 6 months from your initial visit, as other health related factors can be contributing to changes in your prescription. The Glasses Prescription expires TWO YEARS from your last comprehensive eye exam. I have read and understand the Refraction fee:

Signature X ____ _____ Date_____

* Contact Lens Evaluation and Prescribing

A Contact Lens Evaluation and Prescription is an additional service that involves measuring and prescribing the appropriate contact lens for your eye's individual needs. A Comprehensive Eye Exam is required within 6 months of obtaining a Contact Lens Evaluation and Prescription. ***It is necessary to check your contact lenses for a proper fitting and eye health before a written prescription for contact lenses is issued. All contact lens services are regulated under federal law as a medical device. A current contact lens prescription within one year is required to purchase your contact lenses***. Our fees are $149 for a basic sphere lens; $195 for toric (</=2.75), multi- focal, or monovision lens; $250 for high toric (>-2.75) or combination lens; and $700 for keratoconus fits. After 60 days, you will be charged for any additional contact lens related follow up visits. The Contact Lens prescription expires after ONE YEAR. Upon expiration of your prescription, we are unable to sell any contact lenses without an updated prescription. I have read and accept the annual contact lens evaluation fee and management fee.

Signature X ____ _____ Date_____

Advance Beneficiary Notice (For Patient's Using Insurance)

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If your insurance company has not reimbursed our office in full within 90 days, you will be billed for today's visit and your insurance company may then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. In the event that you are billed for your services and you do not make a reasonable effort to make payments, your account will be turned over to a collection agency. You would then be responsible for the full amount of your invoice from Family Eye Health Optometry Center, plus any fees incurred in the collection process.

Signature X _____ Date_____

Acknowledgement of Receipt of Notice of Privacy Policies

Please be advised that a copy of our HIPAA policy is posted in our office, and a copy is available to all our patients. Please ask our staff if you would like a copy of our Privacy Policy today. By signing below, you acknowledge that a copy of Family Eye Health Optometry Center Notice of Privacy Practice was offered to you.

Signature X_____Date_____