Welcome to DePoe Eye Center DATE: _____

We want to welcome you to our practice and appreciate that you have chosen us as your family eye care provider. We believe that there is still a personal touch in medical eye care and strive to offer that family relationship to our patients. This diagnostic form will help us in evaluating both your vision and your total eye and body health. Please take a few moments to complete it. Again, welcome to DePoe Eye Center. PLEASE USE BLACK INK

NAME: LAST: _____ FIRST: _____ M.I. _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Hobbies/Interests: _____ Email Address: _____

Medical Insurance: _____ Vision Insurance: _____

Secondary Insurance (if applicable): _____

May we contact you by: ☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL ☐ TEXT

How were you referred to our office?

☐ Friend or family member: _____ ☐Insurance Company ☐ Yellow Pages
☐ Family Doctor: _____ ☐ Received Mailing ☐ Newspaper
☐ Ophthalmologist: _____ ☐ Internet ☐Other: _____

If this form was filled out by someone other than the patient, please list name and relation: _____

OCULAR HISTORY

Have you ever been diagnosed with any of the following conditions?

Cataract	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
Dry Eye	☐ Y	☐ N
Eye Infection	☐ Y	☐ N
Eye Allergy	☐ Y	☐ N
Iritis/Uveitis	☐ Y	☐ N
Lazy Eye	☐ Y	☐ N
Eye Turn	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Diabetic Retinopathy	☐ Y	☐ N
Macular Degeneration	☐ Y	☐ N
Eye Inflammation	☐ Y	☐ N
Flashes or Floaters	☐ Y	☐ N
Retinal Degeneration	☐ Y	☐ N
Retinal Detachment	☐ Y	☐ N
Eye accident/trauma	☐ Y	☐ N

Any other eye conditions? _____

_____

Have you had any EYE surgeries? ☐ Y ☐ N

_____

_____

Do you have any of the following?

Redness	☐ Y	☐ N
Tearing	☐ Y	☐ N
Burning	☐ Y	☐ N
Itching	☐ Y	☐ N
Discharge	☐ Y	☐ N
Glare	☐ Y	☐ N

Eyeglass / Contact Lens History

Do you currently wear glasses?	☐ Y	☐ N
Do you currently wear contacts?	☐ Y	☐ N
Planning on purchasing glasses today?	☐ Y	☐ N
Interested in wearing contact lenses?	☐ Y	☐ N

MEDICAL HISTORY

Date of last eye exam: _____

Where did you get your last eye exam: _____

Date of last medical exam: _____

Name of Primary Care Physician: _____

Review of Systems: Many diseases of the body have serious eye health consequences. Please answer the following questions related to your overall health. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you have any of the following problems?

General Health ☐ Y ☐ N
Chronic fever, unexpected weight loss/gain, fatigue
Ear/Nose/Throat ☐ Y ☐ N
Hearing loss, sinus problems, sore throat
Neurologic ☐ Y ☐ N
Numbness, weakness, headaches, “blackouts”, MS
Psychiatric ☐ Y ☐ N
Depression, anxiety
Cardiovascular ☐ Y ☐ N
High Blood pressure, heart disease, high cholesterol
Respiratory ☐ Y ☐ N

Shortness of breath, wheezing, coughing, asthma
Gastrointestinal ☐ Y ☐ N
Heartburn, reflux, abdominal pain, diarrhea, vomiting
Genitourinary ☐ Y ☐ N
Painful urination, blood in urine, sex organ problems
Musculoskeletal ☐ Y ☐ N
Arthritis, joint pain, muscle pain
Skin/Integumentary ☐ Y ☐ N
Rashes, excessive dryness, growths, lumps, eczema
Endocrine ☐ Y ☐ N
Diabetes, high or low thyroid, heat/cold intolerant
Blood/Lymph ☐ Y ☐ N
Bruising, unusual paleness, swollen glands, anemia
Immune ☐ Y ☐ N
Frequent infections, allergic reactions, Lupus

Do you have problems with excessive snoring or diagnosed sleep apnea? ☐ Y ☐ N

Females: Are you pregnant? ☐ Y ☐ N
Nursing? ☐ Y ☐ N

Have you ever been treated for any medical conditions? (Ex. Diabetes, hypertension, high cholesterol, arthritis, etc) ☐ Y ☐ N
If yes, please explain: _____
_____
_____

Have you had any surgeries? ☐ Y ☐ N
If yes, please explain: _____
_____

Do you take any medications, including over the counter medications? ☐ Y ☐ N
PLEASE LIST: _____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any **DRUG**, FOOD or ENVIRONMENTAL allergies? ☐ Y ☐ N ☐ NKDA ☐ KDA
PLEASE LIST: _____
_____
_____

FAMILY MEDICAL HISTORY: Do any MEDICAL diseases run in your family (BLOOD relatives)?

Condition			Relative
Diabetes	☐ Y	☐ N	_____
Hypertension	☐ Y	☐ N	_____
Thyroid	☐ Y	☐ N	_____
Cancer	☐ Y	☐ N	_____

FAMILY OCULAR HISTORY: Do any EYE diseases run in your family (BLOOD relatives)?

Condition			Relative
Glaucoma	☐ Y	☐ N	_____
Macular Degen	☐ Y	☐ N	_____
Cataract	☐ Y	☐ N	_____
Blindness	☐ Y	☐ N	_____

SOCIAL HISTORY:
Do you drink alcohol? ☐ Y ☐ N
☐Occasionally ☐1/day ☐2-3/day ☐4+/day
Do you smoke or use tobacco products? ☐ Y ☐ N
☐Occasionally ☐_____ pack/day ☐>2 packs/day

Pharmacy Information:
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone #: _____

Physician Notes: ◉ NKDA ○ KDA
_____
_____
_____
_____
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_____
_____
_____

PLEASE READ THE POLICIES CAREFULLY. WE ASK THAT YOU SIGN THE SECOND PAGE ACKNOWLEDGING YOUR UNDERSTANDING.

Office Policy on Managed Care Insurers and Vision Insurance

In order to accommodate the needs and requests of our patients, we participate in numerous managed care insurance programs and most all vision carriers. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered. Even with the same insuarnce company, the plans differ, depending upon the type of contract your employer has negotiated.

Unfortunately, if you do not inform us of any special requirements in your contract, and we subsequently order services such as testing and/or materials that are not covered, we will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. In the event that services are provided and your coverage is not in effect on the day of service, the claim submitted will be be denied by your carrier and will become your responsibility.

I request that payment of authorized insurance benefits be made to DePoe Eye Center for any services furnished to me by the doctors of DePoe Eye Center. With your cooperation and help, you should be able to receive all benefits offered to you. We will be able to concentrate on caring for your medical and vision needs.

GEORGIA TECH STUDENTS ONLY

Be signing this document, I give DePoe Eye Center the authority to give my name, student ID# and date of my health evaluation to Georgia Tech for reporting purposes only. No further information will be shared.

VISION INSURANCE vs. MEDICAL INSURANCE

We often have patients that have both vision and medical insuarnce. They are different in terms of the services they cover and it's important for our patients to undertstand those differences. Vision coverage is mainly designed to determine a prescription for glasses or contact lenses. It is not equipped to deal with complex medical conditions, diagnosis and/or treatment plans. When a medical diagnosis or condition is present (such as diabetes, glaucoma, dry eye, cataracts, red/pink eye) it is necessary to file the visit with your major medical carrier and the co-payments/deductibles for that insurance will apply as well as any non-covered service. **Our office does not make these rules and they are defined by the insurance carriers themselves.** There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your conveience and we will file those claims for you. In the event that we do not take your major medical medical/vision insurance, we will provide you with an itemized statement/receipt so that you may file with your carrier for reimbursement. If you have questions, please let us know.

Consent for Treatment

I/We hereby authorize DePoe Eye Center to administer diagnostic and medical procedures and treatments as may be necessary for proper health care.

Acknowledgement of Notice of Privacy Practices (NPP)

I, _____, have reieved/read a copy of this office's Notice of Privacy Practices (NPP). Copies will be given at the patient's request.

I give DePoe Eye Center permission to speak with the following (family member / parent):
_____, _____
regarding my account billing and/or treatment needs.

I authorize DePoe Eye Center to correspond with me through the contact information provided to this office via text, voice, and email for reminders, test results, prescription instructions. Billing/insurance, and/or collection purposes.

DEPOE EYE CENTER

Acknowledgement of Financial Policy

The total professional fee is due at the time services are rendered. Any materials (glasses or contact) fees are due at ordering. No materials will be ordered until all fees have been paid. We gladly accept Visa, MasterCard, Discover, American Express, cash and many flexible spending cards. **We are no longer able to accept checks.** We now offer Care Credit as a method of payment with 0% financing for balances up to 12 months.

We will bill for any balances over 30 (thirty) days old. Any account over 60 days old will be subject to a late fee. Full collection proceedings will be utilized for any account aging 90 days, unless prior arrangements have been made.

All No Show appointments will be charged $35.00, if 24 hour notice is not given.

Insurance Information (Major Medical) PRIMARY

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Insurance Information (Major Medical) SECONDARY (if applicable)

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Insurance Information: VISION

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Responsible Account Holder (Parent or Guardian for patient's under age 18)

Name		Salutation	
Relationship		DOB:	
Address			
Home #		Cell #	
Work #		Email:	

Emergency Contact

First Name	Last Name	Relation	Home #	Cell #	Work #	Ext

Please sign below that you acknowledge and understand all the policies above:

Patient Signature: _____ Date: _____