

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation/Hobbie: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M ☐ F: ☐ Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Medical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Do you have any allergies to medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you take (prescription and/or over the counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all major surgeries, eye injuries, and/or Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant and/or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medical History** | SELF | NO | **Family History**  **Relatives (who)** | **Ocular History** | YES | NO |
| Arthritis | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Blurred Vision | ☐ | ☐ |
| Blindness | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Double Vision | ☐ | ☐ |
| Cataracts | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Dryness | ☐ | ☐ |
| Diabetes | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Excess Tearing/watering | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Flashes of Light | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Floaters | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Itching | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Lazy Eye | ☐ | ☐ |
| Lazy Eye | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pain/Eye Strain | ☐ | ☐ |
| Lupus | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Redness | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sensitivity to Light | ☐ | ☐ |
| Retinal Detachment/disease | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Thyroid Disease | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ | ☐ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| If you answer YES to any of the above or have a condition not listed above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

YES NO

Do you wear glasses? ☐ ☐ If yes, how old is your current pair of glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear Contact lenses? ☐ ☐ If yes, what kind of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco/alcohol/illicit drugs? ☐ ☐ If yes, type / amount / how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE COMPLETE THE BACK PAGE***🡪

**FINANCIAL AGREEMENT**

**I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and that final determination can only be made once the claim is processed.** It is my responsibility to provide my insurance information to Westview Eye Care for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of **$40** will be charged on any check returned for insufficient funds. Accounts 90 days old will be submitted to a collection agency.

**I authorize the release of any medical or other information needed to process my insurance claim and request payment for all services today and any future service dates.**

**ANNUAL CONTACT LENS SERVICE FEE**

Contact lenses are medical devices that require proper care and monitoring to ensure good vision and ocular health. **A Contact Lens Service or “Fitting” is the time and knowledge required to prescribe the most appropriate contact lenses for you and your eyes.** This service is *in addition* to your annual eye health exam and is typically not covered by vision plan exam benefits. The contact lens service fee varies by the complexity of your eyes, the type of contacts you require, and the amount of time necessary to achieve a proper fit. This fee is due at the time of your services and is nonrefundable. The service fee covers all “fit-related” follow-up visits for **3 months**. Office visits related to *medical conditions* that may develop will be billed to your *medical insurer*.

**HIPAA PRIVACY: Acknowledgement of Receipt of Privacy Notice**

The Health Insurance Portability and Accountability Act **(HIPPA)** is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at Westview Eye Care, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. **This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls. A detailed copy of Notice of Privacy Practices is attached on the last page and a copy will be provided to you upon request.**

**I have read and understand the Privacy Notice, the Financial Agreement, and the Contact Lens Service Fee policy of Westview Eye Care. By signing below I understand and agree to these terms and my responsibilities as a patient.**

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Patient /Guardian Name (Please print) Patient /Guardian Signature Date