MODERN EYES *WELCOME TO OUR OFFICE*

Date:_____ Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

Mr., Mrs., Ms, Dr. _____ _____ _____ _____
(FIRST NAME) (M.I.) (LAST NAME) (NICK NAME)

Address: _____ Apt.#_____ City/State/Zip _____

Date of Birth/Age_____/_____Social Security No.:_____ Driver's License No.:_____

Employed by: / Occupation _____/_____ Email _____

Vision Insurance: No Yes Insurance Carrier: _____ Group # _____

Medical Insurance: No Yes Insurance Carrier: _____ Group # _____

Other family members (Name & Age)_____Parent's signature if patient is a child_____

Eye complaints today (if any):_____

Vision Concerns: (Check Below)

☐Computer Eyestrain	☐Reading Difficulty	☐Pediatric Evaluation	☐Glaucoma/Cataract	☐Glasses exam	☐Contact exam
☐Interested in Lasik	☐Dry Eye	☐Bifocal Contacts	☐Orthokeratology	☐Vision Therapy	☐Infection

Eye History	No	Yes	General Health History (Your health problems)	No	Yes	Family History (Your family)	No	Yes
Blurred vision			Headache			Blindness		
Loss of Peripheral Vision			Weight loss			Glaucoma		
Double Vision			Ears, Nose, Throat (sinus)			Cataracts		
Dryness, Sandy sensation			Cardiovascular (heart, high BP)			Cancer		
Mucous Discharge			Respiratory (Asthma)			Diabetes		
Redness, Burning			Gastrointestinal			Hypertension		
Itching			Muscle, joint			Heart Disease		
Foreign body sensation			Skin (cancer, psoriasis, eczema)			Kidney Disease		
Tearing/Watering			Neurological (MS)			Stroke		
Glare/Light Sensitive			Psychiatric			Thyroid		
Eye pain			Endocrine (Diabetes)			**Contact Lens User?**	No	Yes
Glaucoma			Blood (high cholesterol)			Daily or Extended wear?	DW	EW
Macular Degeneration			Stroke			Rigid or Soft contacts?	soft	rigid
Light flashes/floaters			Arthritis			Contact manufacturer?		
Eye Surgeries/ injuries			Allergies					
Cataracts			HIV positive			Replacement Schedule?		
Retinal tear or detachment			Smoker					
Lazy eye / wandering eye			Alcohol			Solution?		

Medications Yes / No _____**Allergies Yes / No**_____

(if yes, please list)

PUPIL DILATION - You MUST answer and sign this section ***(INSURANCE COVERS DILATION)***

Dilation of the pupil is now considered standard procedure as part of a comprehensive eye examination. Dilating drops enlarge the size of the pupil (the central black spot of the eye) and allow the doctor a more thorough examination of the retina (back of the eye). Dilation assists in detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal degenerative changes, retinal holes, retinal tears and detachment and some types of tumors. The side effects are light sensitivity while dilation lasts (4 to 6 hours) and trouble focusing up close (2 to 3 hours). It is possible, however unlikely, that dilation could precipitate a sudden rise in the eye pressure, if the doctor determines you are at risk, your pupils will not be dilated. You will usually be able to drive home. There is no cost for Pupil Dilation.

I agree to dilation: __ Yes __ No. **Signature** of responsible party:**X**_____

Referred by (circle): Family Friend Doctor Yellow Pages Internet Newspaper Coupon Walk-in Health Plan

If personally referred, whom may we thank for the referral: _____

Modern Eyes Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our staff. We are dedicated to providing the best possible care and service to you and regard your complete your complete understanding of your financial responsibilities as an essential element of your care.

Unless other arrangements are made in advance, full payment is due at the time of service. For your convenience, we accept MasterCard, Visa, and Discover.

Your Insurance

Insurance claims are filed as a courtesy by this office and we have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those carriers with which we have an agreement and will only require you to pay the authorized copayment at the time of service. Any balance not paid by your insurance carrier is your responsibility and you will receive a statement for payment.

If you have insurance coverage with a carrier for which we do not have a contract, we will be happy to prepare a claim for you to file on an unassigned basis. This means that the charges for services will be due at the time of service and your insurer will send the payment directly to you.

In the event that your health coverage plan determines a service to be "not covered", you will be responsible for the full payment.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.

Contact Lens Patients

Please be aware that the fitting or evaluation of contact lenses is performed in addition to your eye exam and there is a separate fee for this service. This fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. It may not be covered by insurance.

I have read, understand, and agree to the terms of the financial policy of the practice. I also understand that the policy may be amended as needed.

Printed Name of Patient: _____ Date:_____
Signature of Patient (or Responsible Party):_____

Notice of Privacy Practices

I understand that the privacy of Modern Eyes are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I may view and/or print a copy of this Act at my convenience by visiting www.moderneyesaustin.com. I may also request a copy of this act from the staff.

Printed Name of Patient: _____ Date:_____
Signature of Patient (or Responsible Party):_____

Authorization to Release Information

I authorize Modern Eyes to release information to my insurance carrier or to a licensed physician concerning my illness and treatment. I give consent to transmit insurance claim information via secure internet connections to my insurance carrier for claims processing purposes only. I also authorize Modern Eyes to send me mail correspondence, such as recall notices.

Printed Name of Patient: _____ Date:_____
Signature of Patient (or Responsible Party):_____