Patient Information Form

Patient Name _____ Gender _____ DOB _____

Address _____

City _____ Zip_____

Home Phone _____ Cell Phone _____

Ethnicity _____ Would you like to sign up for online access to your health records?_____

Email _____ @ _____*Required for online access to records

Patient Marital Status_____ Occupation _____ SSN _____

Emergency Contact Name _____Phone Number_____

Referred By _____Referral Name_____

Medical Insurance _____ Vision Insurance _____

Primary Policy Holder's Name _____DOB _____ Last 4 of SSN _____

Name of Person to Be Billed (if different from patient) _____

Vision and Medical Information

Date Of Last Eye Exam: Doctor/Clinic Name: _____

Date Of Last Physical Exam: Doctor/Clinic Name: _____

At the time of your examination, do you PLAN to:

☐ Purchase new eyeglasses? ☐ Purchase a new supply of contact lenses?

Regarding your INDOOR life, do you:

☐ Work on a computer? ☐ Have more than one pair of glasses for multiple tasks?

Regarding your OUTDOOR lifestyle, do you:

- ☐ Do a lot of night driving?
- ☐ Read outdoors?
- ☐ Have light sensitivity?
- ☐ Spend time outdoors in direct UV radiation?
- ☐ Have need to protect your eyes while working?
- ☐ Participate in sports that require specific eye wear?

Regarding your GENERAL life, do you:

- ☐ Have a sense of fashion and brand awareness that you would like to meet?
- ☐ Think you might benefit from thinner, lighter-weight lenses?
- ☐ Have an interest in contact lenses (if not currently wearing)?
- ☐ Want detailed information on vision therapy?
- ☐ Have family members in need of eye care?

If you wear Contact Lenses:

- ☐ I am not satisfied with my vision and/or comfort.
- ☐ I wear sunglasses with my contact lenses.
- ☐ I am interested in multifocal contact lenses.
- ☐ I have interest in color-enhanced lenses.
- ☐ I have an interest in trying the latest contact lens technology.

Check any eye conditions, diseases, or procedures that you currently have, or have experienced:

- ☐ Glaucoma
- ☐ Cataract
- ☐ Eye Surgery
- ☐ Strabismus
- ☐ Keratoconus
- ☐ Eye Injury
- ☐ Age-related Macular Degeneration
- ☐ Inflammatory Disorders
- ☐ Eye Patching
- ☐ Retinal Detachment
- ☐ LASIK
- ☐ Other _____

Please use this space to make any additional comments or concerns about your vision:

_____

_____

_____

_____

_____

Please check the box for any disorder that you have now or have experienced in the past:

Constitutional

- ☐ No Disorder
- ☐ Developmental Disability
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other Disorder(s) _____

Integumentary

- ☐ No Disorder
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other Disorder(s) _____

Cardiovascular

- ☐ No Disorder
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other Disorder(s) _____

Allergic/Immunologic

- ☐ No Disorder
- ☐ Drug Allergies _____
- ☐ Environmental Allergies _____
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Latex Allergy
- ☐ Other Disorder(s) _____

Endocrine

- ☐ No Disorder
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other Disorder(s) _____

Neurological

- ☐ No Disorder
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Other Disorder(s) _____

Ears/Nose/Mouth/Throat

- ☐ No Disorder
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other Disorder(s) _____

Musculoskeletal

- ☐ No Disorder
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Other Disorder(s) _____

Respiratory

- ☐ No Disorder
- ☐ Cigarette Smoker _____ Cigarettes/day
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Other Disorder(s) _____

Gastrointestinal

- ☐ No Disorder
- ☐ Ulcer
- ☐ Colitis
- ☐ Crohn's
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other Disorder(s) _____

Hematologic/Lymphatic

- ☐ No Disorder
- ☐ Anemia
- ☐ Leukemia
- ☐ High Cholesterol
- ☐ Large volume blood loss
- ☐ Other Disorder(s) _____

Genitourinary

- ☐ No Disorder
- ☐ Kidney disease
- ☐ Prostate disease/cancer
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other Disorder(s) _____

Psychiatric

- ☐ No Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Other Disorder(s) _____

For Women

Due Date If Pregnant:

Are you a nursing mother?

Do you take birth control?

Please list anything else we should know about your health:

_____

_____

Please list any medications you are currently taking:

_____

_____

Indicate immediate family members with any of the following disorders and their relation to you:

Glaucoma: _____ High Blood Pressure: _____
Macular Degeneration: _____ Diabetes: _____
Cataract: _____ Cancer: _____
Other eye disorders: _____ Other health disorders: _____

LYONS FAMILY EYE CARE

Digital Retinal Photography

Lyons Family Eye Care is excited to offer a high-resolution digital photograph of your retina, the back of your eye.

The Digital Retinography System enhances your comprehensive exam by providing a detailed picture of the retina. These images are advised for healthy patients as well as patients with pre-existing medical conditions. These images are stored in our database and then used for comparison with photographs taken on your next visit. This allows us to follow small changes in the retina that may lead to early diagnosis of serious medical conditions.

Our doctors recommend all of our patients have this procedure to establish a point of reference for future examinations. In most cases, an initial screening photo does not require the pupils to be dilated and is taken before being seen by the doctor. If our doctors determine that you need to have a more extensive photographic study performed, this will be discussed during your exam. Some reasons to have a more detailed retinal photo would include Diabetes, Glaucoma, Macular Degenerations, abnormal screening findings, or an abnormal examination finding.

The initial screening is not covered by insurance; however, we feel this test is important so the fee has been discounted to **$39.00.** Additional testing should be covered by your medical insurance and is subject to your normal medical copay, deductible, or co-insurance.

Please let us know your preference by checking one box below:

☐ Please perform Digital Retinal Imaging as recommended.

☐ I do not wish to have Digital Retinal Imaging performed.

Patient Financial Agreement

Lyons Family Eye Care (LFEC) is a privately owned medical facility that provides medical services on a fee-for-service basis. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), LFEC will submit claims for all necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s), i.e. termination of coverage, coordination of benefits, non-payment of premium, etc.

Deductibles, coinsurance, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of services and/or prior to procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore we may not be able to accurately determine the amount you owe on the date of service or give you an estimation of what you will owe after your insurance company has processed your claim. An LFEC statement will be sent to you after our health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits/statement, please contact your health insurance company member services for clarification of your benefits.

> Please note that LFEC medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.

Copayment(s) as stipulated by your health insurance company are due on the date of service.

Please note that OIG guidelines (FR. Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statuses, as well as contractual obligations to the health insurance companies from whom LFEC will seek reimbursement for medical services prohibit waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that you are uninsured, LFEC and/or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or you elect to have non-covered medical services, LFEC accepts self-pay patients with this signed agreement that payment is due on the day services are rendered.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Lyons Family Eye Care, P.C. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

I also acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize Lyons Family Eye Care to use and disclose my health information for purposes of treating me, obtaining payment of services rendered to me and conduction healthcare operations.

Signature _____ Date _____

Failure to honor your financial obligations to LFEC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulation that govern ethical medical care.