PATIENT HEALTH HISTORY

PLEASE CIRCLE NAME_____ DATE_____

SELF OCULAR HISTORY

Name of last eye doctor_____ Date of last exam_____

Cataract
Glaucoma
Macular Degeneration
Amblyopia (lazy eye)
Strabismus (eye turn)
Contacts
Injury to Eye or Head
Spots or Flashes of Light
Blindness
Retinal Detachment
Ocular Foreign Body Removed
Glasses
Retinopathy of Prematurity
Eye Disease Explain_____
Eye Infections Explain_____
Eye Surgery Explain_____
Other_____

SELF HEALTH HISTORY/ ROS

Name of Regular Physician_____ Date of last Physical Exam_____

CONSTITUTIONAL SYMPTOMS

Trauma / Car accident
Shortness of Breath
Recent Weight Change
Premature Birth
Learning Disability
Fatigue
Fever
Pregnancy

EARS / NOSE / MOUTH / THROAT

Chronic Sinus Problem
Hearing Loss
Onset Date_____
Comment / Surgery_____

RESPIRATORY

Asthma / Bronchitis
Emphysema
Sleep Apnea / Sleep disorder
Onset Date_____
Comment / Surgery_____

HEMATOLOGIC / LYMPHATIC

High Cholesterol
Large Volume Blood Loss
Anemia
Leukemia
Onset Date_____
Comment / Surgery_____

CARDIOVASCULAR

Vascular Disease
High Blood Pressure
Heart Problems
Stroke
Onset Date_____
Comment / Surgery_____

GASTROINTESTINAL

Colitis
Crohn's Disease
Onset Date_____
Comment / Surgery_____

ALLERGIC / IMMUNOLOGIC

Environmental / Food Allergies
HIV / AIDS
Cancer
Lupus
Onset date_____
Comment / Surgery_____

GENITOURINARY

Urinary Tract Infection
Kidney Problems
STD's (HIV, Herpes, Chlamydia)
Onset Date_____
Comment / Surgery_____

ENDOCRINE

Diabetes
Thyroid Problems
Hormonal Dysfunction
Onset Date_____
Comment / Surgery_____

MUSCULOSKELETAL

Arthritis
Fibromyalgia
Muscular Dystrophy
Onset Date_____
Comment / Surgery_____

NEUROLOGICAL

Multiple Sclerosis
Epilepsy
Headaches How often_____
Onset Date_____
Comment / Surgery_____

PSYCHIATRIC

Depression
Nervousness / Panic Disorder
Schizophrenia
Onset Date_____
Comment / Surgery_____

ALCOHOL USE: Never Rarely Moderate Daily Past

TOBACCO USE: Never Present Previous

LIST ANY OTHER HEALTH PROBLEMS_____

PATIENT DRUG ALLERGIES OR SENSITIVITIES_____

FAMILY (BLOOD RELATIVE) HEALTH HISTORY

Cataract
Macular Degeneration
Lazy Eye
Glaucoma
Blindness
Retinal Detachment
Thyroid Problems
Arthritis
Heart Problems / Stroke
Cancer
Diabetes
High Blood Pressure

List any other health problems that run in your family_____

MEDICATION TABLE

Include hormones, birth control, eye drops, non-prescription medications and vitamins

ANNUAL UPDATE

MEDICATIONS	FOR CONDITION	DOSAGE	DATE BEGUN	/ /	/ /	/ /	/ /	/ /	/ /

Comments: Office Use Only

WELCOME TO OUR OFFICE

Patient Name _____ (Circle One) Mr. Mrs. Miss Ms.

Address_____ City & State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth _____/_____/_____ Age _____ Social Security Number_____

Employer_____ Occupation_____

Patient Status: email.

☐ Single ☐ Married ☐ Other Spouse's Name_____

☐ Employed ☐ Retired ☐ Full Time Student ☐ Part time Student

Medical Doctor_____

Eye Doctor last seen_____ Date of last exam_____

Emergency Contact_____ Phone_____

Special Occupational Needs_____

Do you use a computer? ☐ Yes ☐ No How often?_____

Hobbies_____

Sports_____

INSURANCE INFORMATION

RESPONSIBLE PARTY (If different from above)_____

Address_____ City & State _____ Zip_____

Phone_____ Relationship to Patient_____

Does Your Family Have an Account Here? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY_____

Subscriber_____ Date of Birth_____

Social Security Number_____ Employer _____

SECONDARY INSURANCE COMPANY_____

Subscriber_____ Date of Birth_____

Social Security Number_____ Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

PATIENT SERVICE AGREEMENT

Thank you for choosing us as your eye health care provider. Prior to receiving care, please read and sign the following.

* Full payment is due at time of service.

* A minimum of half down is required at time of order with full payment when glasses and/or contact lenses are picked up.

* We accept cash, checks, Mastercard and Visa.

INSURANCE

* Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states,"This is not a guarantee of benefits".

* As a courtesy, we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that some, perhaps all, of the services provided may be deemed non-covered services by your insurance company.

* If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied.

* The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.

* Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers you are responsible for the balance.

USUAL AND CUSTOMARY RATES

* You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

MINOR PATIENTS

* The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized. It is not possible for us to do split billing between accounts.

INTEREST

* We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.

* Collection proceedings will begin on any outstanding balance in non-compliance with this policy.

Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

CLEAR VIEW OPTICAL

1236 GREEN BAY RD

STURGEON BAY, WI 54235

PH (920)743-8884 * FAX (920)743-2519

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information and will be used to:

*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers, who may be involved in that treatment directly or indirectly,

*Obtain payment from third party providers,

*Conduct normal health care operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy and Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date Initials Reason