Welcome to The Vision Center

Patient Information

DATE: _____/_____/_____
Last Name _____
First _____MI _____
Street _____
City _____State _____
Zip Code _____
Date of Birth(patient)_____Age _____
Sex M F
Home Phone _____
Work Phone _____
Cell Phone _____ OK to text? Y N
E-mail Address _____
If under18, Guarantor_____
Guarantor SSN_____
Employer (or School) _____
Occupation (or Grade) _____
What is the major purpose of this visit?

_____

_____

NEW PATIENTS ONLY:
How did you choose our office?
❑ Insurance List
❑ Newspaper/Radio/TV (circle)
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Referred by _____

Insurance Information

Vision Insurance _____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____/_____/_____
Primary Medical Insurance_____
Subscriber Name_____
Subscriber ID_____
Subscriber Birth Date_____/_____/_____

Advanced Testing Offered

optomap®
Retinal Exam

In our continued efforts to bring the most advanced technology to our patients, we are proud to announce the inclusion of the **Optos Daytona Retinal Exam** as an integral part of your exam today.

Our doctors are concerned about retinal problems including macular degeneration, glaucoma, retina holes or detachments, and systemic diseases such as diabetes, stroke and high blood pressure. These conditions can lead to serious ocular or health problems, including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.

Optos Retinal Exam Benefits:
- An in-depth view of the retinal layers where diseases can start. (See video on monitor)
- Provides a panoramic digital image at the time of your exam to discuss and answer questions about your eye health.
- This also provides an annual, permanent record on your medical file, which gives doctors comparisons for tracking and diagnosing potential eye disease.

Optos Retinal Exam	Dilation
No blurry vision	Blurry vision 3-5 hours
No Light Sensitivity	Light Sensitive 4-6 hours
Takes less than two minutes	25 minutes longer exam time
Permanent digital image	No permanent record of retina

Insurance typically does not cover any advanced screening technology beyond the general exam, but it is eligible for flexible spending account reimbursement. **Our doctors highly recommend the Optos Retinal Exam for all patients. This will be done as an enhancement to the general eye exam for a fee of $35.**

Our recommendation is an annual retinal evaluation including Optos Retinal photo; if there are any risk factors detected we will proceed with a dilation to further assess any concerns.

_____**Accept Optos Photo ($35)**
_____**Decline - I would prefer to be dilated (no charge)**
_____**Decline both Optos & Dilation**

Signature On File: I authorize release of any information to my insurance company necessary to process a claim; I authorize payment to be made directly to The Vision Center/Dr. John Plow; I authorize use of this form on all my insurance submissions and permit a copy of this authorization to be used in place of the original; I understand that I am responsible for payment of any charges not paid for by my insurance, including any co-payments not collected at time of order; I understand this office does not in any way guarantee payment for services/eyewear by accepting my insurance plan and that all insurance benefit amounts quoted are estimates received from your insurance company and actual amount due from you may change after insurance claim processing. I have also read or been offered a copy of our HIPPA Privacy Practices.

X _____Date_____

Office use only: Dr: P O rM dM Comp CL Medical VF OCT Optomap ID#:

Medical History

Family Physician_____
Location_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills and what they treat)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Has a **blood relative** ever been diagnosed with the following? If **yes,** what is their relationship to you?

Blindness ❑_____
Cataracts at young age ❑_____
Corneal Problems ❑_____
Diabetes ❑_____
Glaucoma ❑_____
Heart Disease ❑_____
Lazy Eye ❑_____
Macular Degeneration ❑_____
Retinal Problems ❑_____

Are you nursing/pregnant? ❑ Yes ❑ No

Any allergies to medications? ❑ Yes ❑ No
If so, what medications? _____
_____

Have you had any eye surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Unusual weight losses/gains	❑	❑
Diabetes/Endocrine	❑	❑
Thyroid	❑	❑
Digestive	❑	❑
Genitourinary	❑	❑
Kidney	❑	❑
Ears/Nose/Throat	❑	❑
Blood/Lymph	❑	❑
Immunologic	❑	❑
Skin/ Eczema/Rashes	❑	❑
Arthritis	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Cancer	❑	❑

Patient History

Do you……(check box if your answer is yes)

❑..work at a computer? Hours per day_____
❑..think you might prefer thinner, lighter lenses?
❑. have interest in a trial of the latest contact lens design?
❑..spend time outdoors? Hours per week_____
❑..have prescription sun wear?
❑..enjoy fishing, boating or skiing?
❑..prefer not to wear your glasses at times?
❑..have more than 1 pair of current Rx eyewear?
❑..have children or other family members needing eye care?
If you wear bifocals, does the visible line bother you? Y N

Have you recently experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Burning
❑ Occasional dryness
❑ Tearing
❑ Double Vision
❑ Flashes of light
❑ Floaters/Spots
❑ Grittiness
❑ Headaches
❑ Itchiness
❑ Sunlight Sensitivity
❑ Trouble seeing/driving at night
❑ Uncomfortable glasses
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Corneal Abrasions
❑ Eye Infections
❑ Eye Injury
❑ Glaucoma
❑ Macular Degeneration
❑ Retinal Detachment
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Other eye disorders

Date of Last Eye Exam _____

By Whom? _____

Do you wear glasses?(circle) Distance, Near, Bifocal

Have you ever tried contact lenses? ❑ Yes ❑ No
Are you interested in trying contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? _____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No
Would you prefer contacts that do not require daily cleaning? ❑ Yes ❑ No

THE VISION CENTER

Insurance Policy

There are two types of health plans that will help pay for your eye care products and services. You may have both types, and The Vision Center accepts most plans:

1. **Medical insurance (such as Empire Plan, Blue Cross/Blue Shield, Medicare and others).**

2. **Vision discount plans (such as Davis, VSP, EyeMed and others)**

- Determination of which type of plan is to be billed for your visit can only be made by examining you first. The examination will determine this by taking into consideration several pieces of information, including, but not limited to: reason for visit, personal and family history, clinical findings, and your ultimate care plan. Therefore, there is no way to know for certain before your examination the exact plan that is responsible for being billed. We will do our best to inform you of which plan is to be billed after the examination and what your financial responsibility will be.
- Medical insurance is primary and will be billed first in most cases. If your vision plan allows for coordination of benefits (COB), then we will attempt to bill them as secondary. Medical insurance must be used for medical eye care. Refraction (checking your prescription) is not a covered service under most medical insurance, and will be due at the time of service ($30.00 charge).
- Vision plans only cover "wellness screenings", along with eyeglasses and contact lenses. Vision plans will only be billed for the examination of your eyes if there is no abnormal finding during the exam (i.e. Only nearsightedness, farsightedness, astigmatism, etc).
- Vision plans do not cover medical eye care (the diagnosis, management or treatment of current or potential eye health problems).
- Medical insurance must be used if you have an eye health problem (i.e. dry eyes, cataracts, infections) or a systemic health problem that has possible ocular complications (i.e. Diabetes). This includes medications that have ocular side effects (i.e. Plaquenil). Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- **ANNUAL EYE HEALTH EXAMS FOR DIABETIC PATIENTS WILL ONLY BE BILLED TO YOUR MEDICAL INSURANCE, BUT YOU MAY USE YOUR VISION PLAN FOR EYEWEAR.**
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits (COB) to do this properly and to minimize your out-of-pocket expense.
- Your insurance policy is a contract between you and your insurance company. We will attempt to verify your coverage ahead of your appointment. Although we are familiar with most plans, we may not know exactly what your coverage is for a particular product or service. It is your responsibility to understand your plan before your appointment.
- We will try to collect all co-payments due while at the office, but if we fail to collect all co-pays or our reimbursement from your insurance company is less than was estimated while at our office, we will bill you for the amount allowed in your policy. Some examples of these charges are: deductibles, co-payments or non-covered products or services. Please provide your insurance cards to our staff member so we can make copies, as we will need to have all information on file in order to bill the proper plan on your behalf.

Acknowledgement:

I understand the information I've just read about the difference between vision plans and medical insurance and I authorize Plow Optometry PC/The Vision Center to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signature On File:

I authorize release of any information to my insurance company necessary to process a claim; I authorize payment to be made directly to Plow Optometry PC/The Vision Center; I authorize use of this form on all my insurance submissions and permit a copy of this authorization to be used in place of the original; I understand that I am responsible for payment of any charges not paid for by my insurance, including any co-payments not collected at time of order; I understand this office does not in any way guarantee payment for services/eyewear by accepting my insurance plan and that all insurance benefit amounts quoted are estimates received from your insurance company and the actual amount due from you may change after insurance claim processing.

Guarantor on Account _____ Date _____