



Patient Name:

Date: (mm/dd/yy)

By what name do you or the above person prefer to be called?

Parent's names (if patient is under 18):

ADDRESS: _____ **CITY:** _____ **Zip:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____ **Email address:** _____

PHONE #: Home: _____ **Work:** _____ **Cell:** _____

GENDER: M F **MARITAL STATUS:** SINGLE MARRIED WIDOWED DIVORCED

OCCUPATION: _____ **PLACE OF EMPLOYMENT:** _____

STUDENT: Yes No **NAME OF SCHOOL:** _____ **GRADE:** _____

PERSON RESPONSIBLE FOR BILL (If different from patient):

Relationship to patient: Spouse Parent Other

Address (If different from patient's): _____

Phone numbers (if different from patient's): _____

CUSTODIAL PARENTS NAME: _____ **Relationship:** _____

Address: _____ Phone: _____

DO YOU HAVE VISION INSURANCE THAT COVERS GLASSES OR CONTACTS? Y N
(List Name) _____

DO YOU HAVE MEDICAL INSURANCE: Yes No (ex. Medicare, Anthem) List: _____

Policyholder's name: _____ **DOB:** _____ **SS#:** _____

FAMILY PHYSICIAN: _____ **DATE LAST SEEN:** (mm/dd/yy) _____

DATE OF LAST EYE EXAMINATION: _____ **BY WHOM?** Us Other List: _____

WHAT IS THE MAIN EYE PROBLEM YOU ARE HAVING?

HOBBIES:

OTHER FAMILY MEMBERS WHO ARE SEEN HERE:

THE FOLLOWING QUESTIONS ARE DESIGNED TO HELP US BETTER HELP YOU.

PLEASE CHECK YES OR NO (Assume you are properly wearing your eyeglasses or contacts if you have any):

EYE INFORMATION	Yes	No	EYE INFORMATION (cont.)	Yes	No
Difficulty with distant vision	<input type="checkbox"/>	<input type="checkbox"/>	Excessive tearing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with near vision	<input type="checkbox"/>	<input type="checkbox"/>	Color vision problems	<input type="checkbox"/>	<input type="checkbox"/>
Significant eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Ever had lazy eye (amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>
Using eyes causing headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>
Greatly bothered by bright light	<input type="checkbox"/>	<input type="checkbox"/>	Currently wear eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>
Frequent eye dryness or burning	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Recent onset of spots or floaters	<input type="checkbox"/>	<input type="checkbox"/>	Currently wearing contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Recent onset of flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	Wear sunglasses	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU WORK ON A COMPUTER, DO YOUR EYES BOTHER YOU? YES NO

I WOULD LIKE INFORMATION ON (please check): CONTACT LENSES REFRACTIVE SURGERY

ANY SPECIAL REQUEST?

PERSONAL EYE HISTORY	Yes	No	If Yes, Type	Date (mm/dd/yy)
Have you ever had an eye operation(s)?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had an eye injury(s)?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had any eye disease(s)?	<input type="checkbox"/>	<input type="checkbox"/>		

CURRENT GENERAL HEALTH	Yes	No	CURRENT GENERAL HEALTH (Cont.)	Yes	No
Is your general health good?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with?		
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you use smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
# of glasses per day			Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with?			Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease: AIDS, Herpes, Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, TIA's, or Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>

OTHER HEALTH PROBLEMS:

LIST ANY RECENT SURGERIES:

DO YOU TAKE ANY EYE MEDICATION (including non-RX drops)? YES NO (List):

LIST ALL OTHER MEDICATIONS YOU ARE TAKING:

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO (List):

Do you have a FAMILY HISTORY of:	Yes	No	Do you have a FAMILY HISTORY of:	Yes	No
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Eye Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>

How did you hear about us? (new patients)

Insurance Direct Mail Newspaper Yellow Pages Website Other

Referred by _____ (we'll thank them!)

SIGNATURE RELEASE: I authorize payments of benefits per assignment to ProCare Vision Center and assume responsibility for charges related to my care for the next year and any fees associated with collection of these charges. I authorize the release of information necessary to this benefit claim. I understand that my co-payments and a deposit for any materials ordered are due today and the balance due on delivery. If proper insurance is not presented at time of service, no back adjustments will be made. I allow my examination findings to be shared with other professionals responsible for my care. I acknowledge that I received a copy of ProCare Vision Center's Notice of Privacy Practices.

Signed: _____ (relationship:) **Date:** _____ (mm/dd/yy)

Please list with whom we may share information regarding your eye care:

Name _____ Relationship _____

Name _____ Relationship _____

Doctors Signature **Date:** _____



FINANCIAL & APPOINTMENT POLICY AGREEMENT

We truly appreciate you entrusting us with your eye health. We are a family, and we welcome you and your family. As professionals, we strive for excellence in eye care. But to do this, we need your help. To achieve this goal we have outlined specific appointment and financial policies. It is important that you know and understand these so we can serve you and all of our patients to the best of our ability.

ProCare Vision Center will gladly submit your insurance for you and process it according to how your insurance company responds. However, it is your responsibility to know and understand your insurance. If you have questions regarding your coverage or the payment rendered by your insurance, you will need to call either your insurance company or your Human Resources Department. We cannot predetermine how your insurance will process your bill. Co pays listed on your card will be required as payment for each service date. If your card lists a specialist co pay or has required a previous co pay not listed on your card, you will be charged this amount. You are responsible for any part of the bill that your insurance does not cover. Payment for service is due at the time service is rendered, either by cash, check, Visa, MasterCard, Discover or financing through the Citi Health Card. **If you do not have payment at the time of service, a \$15 service fee will be attached to your account.**

We require a copy of any insurance cards you have at each date of service. If you do not bring your insurance card, we have the right to expect payment in full and bill your insurance later or to reschedule your appointment. If correct insurance is not provided at the time of service, we cannot make any monetary adjustments at a later date.

After your insurance has processed your claim, we will send you a billing statement. If no payment or payment arrangements have been made by the 2nd billing statement, a finance charge of 10% will be applied to the remaining balance. **If you have not responded to billing statements or requests for payment by phone**, we will apply the unpaid balance to your credit card. By signing this agreement, you hereby authorize Procare Vision Center to apply to your credit card any amount due and owed on your account. Credit card numbers are NOT kept on file. All services and warranties will be held. If the bill is submitted to a collection agency, you will be responsible for all collection fees.

There will be a **\$25 fee** for any check returned for insufficient funds. Payment due must be paid by cash or credit card.

If you are owed a refund and paid by cash or check, we will refund the money to you by check after your check has cleared. If you paid by credit card, the money will be refunded to you on the same credit card.

When your glasses order has come in, we will notify you. **If you have not picked up your glasses nor notified us 30 days after this notice, any amount you have paid as down payment on the glasses will be forfeited.**

APPOINTMENT POLICY

An appointment in our office is reserved specifically for you and the doctor. To give full attention to you, we do not "double book" our schedule. We also leave room in our schedule for "emergency patients" who have urgent needs.

If you are unable to make your reserved time, we ask you call our office at least 24 hours in advance. A "no show" appointment is when a patient fails to come in or call us with a 24 hour advance notice.

Because we know that things in life happen, you will be given 1 chance to miss an appointment. On the second "no show", you may be charged a \$25 missed appointment fee and this must be paid before another appointment will be scheduled. After 3 "no show" appointments, you and your family may be dismissed from the practice.

Signing below indicates you have read, understand, and agree to comply with our financial & appointment policy.

Signature

Date

Print patient name



PATIENT CHECKLIST

- **Bring all forms, medical insurance cards, vision insurance cards or information regarding your benefits.**
- **If you wear contact lenses, please wear them to your appointment and bring any boxes of lenses that you may have.**
- **Bring any glasses, including prescription sunglasses with you for your exam.**
- **Payment is required on glasses and/or contact lens materials before the order can be placed.**
- **Co-payments are required and due at the time of service. If you do not bring payment for your co-pay, we reserve the right to charge you a \$15 billing fee.**
- **Expect a contact lens fitting charge if you are interested in contact lenses.**
- **If we are not provided with the appropriate insurance information at the time of service, you will be financially responsible for all charges incurred and the filing of your own insurance claim.**
- **A parent or legal guardian must accompany patients who are minors (under 18 yrs of age) to their visits.**
- **Cancellation and No Show appointments:**
 - If you are unable to keep your appointment, kindly give us 24 hours notice prior to your scheduled appointment time.**
 - We reserve the right to charge a \$25 fee for not notifying us within 24 hours.**

**If you have any insurance or billing questions, please call 937-251-9754.
For all other calls, you may contact us at 937-339-7956.**