GRANDVIEW OPTOMETRY

Personal Information

Last Name: ______________________________ First Name: ______________________ DOB: ___/____/____ Gender: M/F

(*If patient is a minor, name of parent or guardian*: ____)

Address: ____ City: ____________________State: _____ Zip: ___________

Home: (_____) ________________Cell: (____) _________________Email: ____

Employer: _________________________________ Occupation: ____

Who do you authorize to pick up your scripts or discuss your health? ____

Who is responsible for payment? ☐ Self ☐ Other: _________________________ Relationship to Patient: __________________

Would it be okay to contact you or send you messages via text? ☐ Yes ☐ No

Personal History

What is the reason for today's exam? ☐ Update glasses prescription ☐ Update contact prescription ☐ Medical Visit
☐ First Eye Exam ☐ Other: ____

Have you worn contact lenses in the past? NO YES If yes, do you wear SOFT or HARD contacts.

Date of last eye exam: ______________Age of present glasses: _________ ☐I have filled my prescription at Costco.

MEDICATIONS: ☐NONE ☐ I HAVE A LIST TO GIVE TO THE FRONT DESK, otherwise please list your medications:

____

____

Do you have any allergies to medication or other? ☐ NONE ____

Personal Eye History: ☐ NONE

☐ dry eye ☐cataracts ☐glaucoma ☐ retinal disease ☐ macular degeneration ☐ strabismus ☐ iritis/ uveitis ☐ floaters

☐ flashes of light ☐ double vision ☐ previous eye injuries ☐ previous eye surgeries: ______________

Personal Medical History: Circle all that apply or : ☐ I have no medical conditions to report

Allergies/ Immune:	seasonal, medical, environmental, lupus, Sjogren's syndrome
Cardiovascular:	hypertension, heart disease, congestive heart failure
Ear/ Nose/ Throat:	hearing loss, dry mouth, vertigo, sinus conditions
Endocrine:	thyroid dysfunction, diabetes I, diabetes II (Current A1c level: _____ approx. date tested:_______
Hematologic/ Lymph:	cholesterol, anemia
Integumentary:	eczema, rosacea, psoriasis, shingles
Muscular/Skeleton:	arthritis, fibromyalgia, muscular dystrophy
Neurological:	multiple sclerosis, epilepsy, stroke, migraines
Pregnant or Nursing:	# of weeks pregnant _______
Psychiatric:	depression, anxiety, ADHD
Respiratory:	asthma, sleep apnea, COPD, emphysema,

Other conditions: ____

Family History: glaucoma, macular degeneration, retinal disease, other: _______________________________☐ NONE

Family Medical History: diabetes, high blood pressure, cholesterol, cancer, heart disease, other: ___________☐ NONE

Social History: smoker, former smoker, alcohol, recreational user ☐ NONE

Please read and initial our Office Policies below:

HIPAA Privacy Policy

____ Grandview Optometry will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. A detailed privacy statement can be provided upon request. Federal Law required that you be made aware of your privacy rights regarding your personal medical information**.**

Financial Policies and Assignment of Benefits

____ Payments are due at time of service. For our patients with insurance, our contracts with insurance companies require us to collect your co-pay at the time of service. Payment is also due at time of service for any portion of your visit not covered by your insurance. We accept cash, check, and Visa/Mastercard. If your personal check is returned due to non-sufficient funds, a returned check fee of $25.00 will be charged to your account.

____ Glasses prescriptions are guaranteed for 90 days from the date of exam. Any changes to the prescription occurring after the 90 days from the date of exam will incur an office visit fee.

____ Contact lens follow-up care will be charged as an office visit if beyond 90 days of exam or after a contact lens prescription has been dispensed. Contact lens care beyond six months from date of exam will incur a new exam fee. First time contact lens wearers are required to be trained in office prior to release of contacts. Each hour of training is $25.00.

____ As a courtesy to our patients, we will file your insurance claim after each visit. If your insurance company has not paid your claim within 90 days, you will be required to pay in full. Our office does not enter into disputes with insurance companies over coverage. It is your responsibility to resolve any dispute over payments by your insurance.

____ Should a billing statement be sent to you, you will have 30 days to pay any outstanding balance. Thereafter, late payment charges of $8.00 per month will be added to your account. In the event your account is forwarded to collections, you agree to reimburse our the office the fees of any collection agency and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

____ Many patients have both medical and vision benefits. Vision Plans are designed to cover a prescription for glasses and help pay for lenses. It is not intended to cover medical conditions and treatments. Medical insurance applies to situations when a medical problem affects the eyes (such as diabetes, cataracts, and glaucoma, to name a few). When such conditions are being managed, we submit a claim to the medical insurance and co-pays, deductibles, and co-insurance will apply. Vision plans do not cover these issues. We are obligated to comply with the regulations set forth by insurance companies.

____ If we are not on your insurance company's panel, we can provide you, upon your request, with an itemized receipt so that you may file a claim with your insurance company for reimbursement. The amount of reimbursement depends on the your vision plan coverage.

____ Professional fees for services rendered are non-refundable.

I hereby authorize Grandview Optometry to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature or digital signature to be used in processing claims for the period of a lifetime. This order will remain in effect until revoked by me in writing**. I have requested medical services from Grandview Optometry on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full upon presentation of statement.** A photocopy or digital copy of this assigment is considered as vailid as the original.

By signing below, you are acknowledging that your have read and agree to all the above stated policies.

X____ Date: _______________

Patient Signature (If Guardian, please sign above and PRINT YOUR NAME:____)