Rocha Family Eye Care

Patient Information **Date___/___/_____**

Last Name:_____First:_____M.I.___

Address: **__**_____

City:_____State:_____Zip:_____

Cell Phone: ( )_____Alternate Phone: ( )_____

Date of Birth:____/____/____ Age:_____ SS or Last 4:_____/_____/_____

Email:_____ Marital Status: Single / Married / Widowed / Other

Occupation:_____Employer:_____

Do you have the following **Medical Insurance**? **AETNA / MEDICARE / CIGNA**
BLUE CROSS BLUE SHIELD / UNITED HEALTHCARE /
WELLCARE / AMERIGROUP / MEDICAID

Your **Vision Plan** (if any): **EYEMED / HUMANA / DAVIS FEP / SUPERIOR / MARCH**

If yes, who is the primary insured on this plan? **SELF / SPOUSE / PARENT / OTHER**

If not yourself: **Name of primary insured**:_____**Their Date of Birth**:____/___/____

Their SS or Last 4:_____/_____/_____

When was your last eye exam? _____

Do you **CURRENTLY** wear contact lenses? **Y N**

If yes, what brand? _____ Are they Monthly/ Bi-weekly/ Daily

If not, are you interested in a contact lens fit & evaluation today? (**See Note Below**) **Y N**

******* If you wear contacts, an annual contact lens evaluation is **medically necessary**. Along with updating your prescription, the doctor will check the health of the eyes, curvature of the cornea, inspect the eye for microscopic complications, abnormal blood vessel growth related to wearing contacts and evaluate the fit of the contacts on the eyes every visit.

PLEASE NOTE THAT A CONTACT LENS EXAM IS DIFFERENT FROM AN EYE EXAM AND DIFFERENT CHARGES MAY APPLY.

REVIEW OF SYSTEMS:

Do you have any medical problems involving the following areas?

(Please circle YES or NO and describe if any)

Respiratory.....Y N_____
Skin/ Dermatologic.....Y N_____
Ear, Nose, Throat.....YN_____
Immune System.....Y N_____
Thyroid/Other Glands.....Y N_____
Gastrointestinal/Liver.....YN_____
Genitourinary.....Y N_____
Neurological.....Y N_____
Lymph Nodes/Blood Disorders.....Y N_____
Fever/Weight Loss or Gain.....Y N_____
Bones, Muscles, Joints.....Y N_____
Psychiatric.....Y N_____
Do you smoke? Y / N if yes, how much?_____
Drink alcohol? Y / N if yes, how many drinks per week?_____

Do **you or blood relatives** have any of the following health problems?
(If yes, please specify SELF or FAMILY)
High blood pressure / Diabetes / Heart Problems / Stroke / Cancer / NONE

Explain if needed:_____

What medications / vitamins (if any) are you currently taking?_____

_____

Are you **allergic** to any medications or eye drops?_____

Do **you or blood relatives** have any of the following eye conditions?
(If yes, please specify SELF or FAMILY)
Glaucoma / Macular degeneration / Retinal disease / Corneal disease / NONE

_____

Have you ever had an eye injury, eye surgery, or other serious eye problem?

Explain:_____
Do you see flashes of light or floating spots? **Y N**
Do you have severe / frequent headaches or eye pain? **Y N**

ACKNOWLEDGEMENT OF OFFICE POLICIES

- ***Payment for all services and copays is expected in full at the time of your visit.***
- ***Please keep in mind that your insurance is a contract between you and your insurance company. Therefore, any copays, deductibles or co-insurances that may apply to your plan cannot be waived by our office. Medical eye visits and routine vision exams are different and are often covered under different insurance plans which cannot be used together at the same visit. We try to do our best to find your insurances and get an authorization prior to your exam.***
- ***Vision is complex and oftentimes adjustment to new prescriptions can vary from patient to patient. If you are unhappy with your new glasses or contact lens prescription, you have up to thirty (30) days from the date of your examination to come in for a complimentary recheck. After the thirty day, period ends, there will be a $20 fee for any additional rechecks. If you return for any rechecks after 90 days, a new full examination will be required.***
- ***Patients have up to 90 days from the date of their initial exam to return for a contact lens evaluation. However, after the 90 day period, a new full examination will be required, as vision and ocular health can often change quickly.***
- **Professional fees are non-refundable after services have been rendered**

Patient (Parent/Guardian) Signature:_____Date:_____

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HIPPAA / ACKNOWLEDGEMENT OF RECEIPT

This is to notify you that any information you provide us and any information created in the course of providing services to you will only be disclosed or used for the purposes of treatment and care to conduct healthcare operations in our office.

Patient (Parent/Guardian) Signature:_____Date:_____

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SIGNATURE ON FILE / RELEASE OF INFO / ASSIGNMENT OF BENEFITS

I authorize the release of the above information to my insurance carrier(s) in order to determine the benefits payable for services rendered. I authorize the doctors in this office to act on my behalf in obtaining payment from my insurance company and that these benefits be made payable to them. ***I understand that I am responsible for any co-pays, deductibles that have not been met and charges not covered by my insurance.*** This services as a lifetime signature on file form solely for the purposes stated above.

Patient (Parent / Guardian) Signature:_____Date:_____

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