

WELCOME TO EYETIQUE

Thank you for choosing Eyetique. In order for us to maximize your vision benefits, please fill out this form as completely as possible.

Patient Demographic Information

Last Name		First Name		Middle Initial	Date of Birth	Age	Social Security Number		
Street Address					Apartment	City		State	Zip Code
Home Phone Number	Mobile Phone Number		Work Phone Number		Email Address				
Gender	Employer			Occupation					

If Patient is a Minor (for financial purposes)

Parent or Guardian Full Name		Relationship to Patient		Parent/Guardian Date of Birth		Parent/Guardian SSN (optional)			
Parent/Guardian Street Address					Apartment	City		State	Zip Code
Parent/Guardian Phone Number		Parent/Guardian Employer		Parent/Guardian Occupation					

Primary Vision Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Secondary Vision Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Primary Medical Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Secondary Medical Insurance

Name of Insurance	
Policy Holder Name	
Policy Number	Group Number

Policy Holder Information

Policy Holder Full Name		Relationship to Patient		Policy Holder Date of Birth		Policy Holder SSN (optional)			
Parent/Guardian Street Address					Apartment	City		State	Zip Code
Parent/Guardian Phone Number		Parent/Guardian Employer		Parent/Guardian Occupation					

Statement of Financial Responsibility

In order for Eyetique to service my account, or to collect any amounts I may owe, I agree I may be contacted at any number or address I have provided. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe. I understand that I am solely responsible for the cost of all non covered items, as outlined in detail on my receipt, which includes the specific date of service, description of each procedure/ service, and the amount I am responsible for paying out of pocket. I certify that I have been informed of all items and cost. Our office will file all vision claims if we are a participating provider for your plan. However, if your insurance denies payment for any claims submitted, you will be responsible for full payment. Otherwise we will supply you with an itemized statement which you may submit to your insurance carrier.

Patient Printed Name	Patient Signature	Today's Date
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Continue on reverse side

Patient Medical Information

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you.

Yes No Have you had any eye injuries, eye surgeries, eye diseases, floater or flashes of light? Explain below:

Yes No Breathing Problems
 Asthma Emphysema

Yes No Skin Condition
 Eczema Rosacea

Yes No Endocrine Disorder
 Diabetes Thyroid Disorder

Yes No Stomach Problem
 Heartburn

Yes No Heart Problem
 High Blood Pressure Heart Failure

Yes No Blood Disorder
 Sickle Cell High Cholesterol

Yes No Allergy/Immunology
 Hay Fever HIV Lupus

Yes No Kidney/Bladder Problem

Yes No Surgical Operations

Yes No Fever/Fatigue/Weight Loss

Yes No Cancer

Yes No Musculoskeletal Conditions

Arthritis Osteoporosis

Yes No Ear/Nose/Throat Problems

Sinus Problems Dental Problems

Yes No Neurological Disorder

Migraines Multiple Sclerosis

Stroke Myasthenia Gravis

Head Injury

Yes No Sexually Transmitted Diseases

Yes No Other Autoimmune Disease

If yes, what: _____

Yes No Are you currently being treated for any other medical conditions?

If yes, what: _____

Yes No Psychiatric Disorder

Date of last health exam: _____ Date of last eye exam: _____

Previous eyecare provider: _____

Please list any medications you are currently taking:

Are you allergic to any medications? Yes No If yes, please list:

Are you currently nursing or pregnant? Yes No

Is there any possibility that you might be pregnant? Yes No

Do you smoke or use tobacco? Yes No Less than 1 Pack a Day 1-2 Packs a Day 2 Packs a Day

Do you drink alcohol? Yes No Social 1-2 Drinks Daily Above Average Use Dependence

Has anyone in your family had (please list their relationship to you):

Yes No Diabetes: Yes No Cataract: Yes No Blindness:

Yes No High Blood Pressure: Yes No Glaucoma: Yes No Cancer:

Yes No Heart Disease: Yes No Macular Degeneration: Yes No Other Eye Disease:

Yes No Respiratory Disease:

Do you currently wear contact lenses? Yes No

If yes, what brand?

How many hours do you wear your lenses each day? < 4 4-8 8-12 12 +

How often do you throw away your lenses? Daily Weekly Bi-weekly Monthly Yearly

Notice of Information Practices and Privacy Statement

The HIPAA Policy was available to read during my office visit Yes No

Patient Printed Name

Patient Signature

Today's Date

Additional Testing

Initial Optomap: Our retina (located in the back of your eye) is the only place in the body where blood vessels and a nerve can be seen directly. This means that in addition to eye conditions, signs of other diseases (ex: stroke, heart disease, hypertension and diabetes) can also be seen in the retina. The optomap provides a 360 degree view for the Physician to diagnose and monitor change without dilation. Optomap photography is \$39.00.

Initial Fundus: The fundus photo is a specialized low power microscope with an attached camera designed to photograph the interior surface of the eye, including the retina, retinal vasculature, optic disc, macula, and posterior pole. The retina is imaged to document conditions such as diabetic retinopathy, age related macular degeneration and macular edema. Dilation may sometimes be necessary to obtain these photos. Fundus photography is \$20.00.

Initial Visual Field Test: A routine exam may not detect diseases early enough to prevent permanent vision loss. A visual field test evaluates your peripheral vision and may alert us to the presence of potential vision-threatening diseases such as Glaucoma, tumors, neurological diseases, and retinal detachment. This test can also detect certain systematic diseases such as hypertension, lupus, and diabetes, all of which can also lead to vision loss. The visual field test is \$20.00.

Office Use Only: Entrance Prescription

Eyeglass Prescription

Contact Lens Prescription