

**Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Do you have supplemental insurance?**       No    Yes      **If yes, please complete the following:**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

# Oak Hill Eye Care Patient Health History

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Preferred Contact Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Emergency Contact Name/Phone Number: \_\_\_\_\_ Relation to You: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Do you have vision insurance?  No  Yes If yes, Insurance Carrier: \_\_\_\_\_

Do you have health insurance?  No  Yes If yes, Insurance Carrier: \_\_\_\_\_

Do you have Medicare?  No  Yes

## OCULAR HISTORY

Current vision correction:  Glasses  Contact Lenses  None

Currently experiencing difficulty with: Distance Vision  No  Yes Near Vision  No  Yes

Please list prescription and non-prescription medication you are currently using *for your eyes*: \_\_\_\_\_

Have you ever had eye surgery?  No  Yes

If yes, please indicate:  Right Eye Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Left Eye Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had an eye injury?  No  Yes If yes, please describe: \_\_\_\_\_

### Do you currently have any of the following symptoms?

Eye pain  No  Yes

Blurry vision  No  Yes

Double vision  No  Yes

Flashes of light  No  Yes

Floaters  No  Yes

Light sensitivity  No  Yes

Glare/halos  No  Yes

Redness  No  Yes

Itching  No  Yes

Burning  No  Yes

Dryness  No  Yes

Foreign body sensation  No  Yes

Gritty sensation  No  Yes

Other: \_\_\_\_\_

### Have you been diagnosed with any of the following conditions?

Glaucoma  No  Yes

Macular degeneration  No  Yes

Cataracts  No  Yes

Retinal tear/detachment  No  Yes

Lazy eye (amblyopia)  No  Yes

Dry eye syndrome  No  Yes

Ocular allergies  No  Yes

Other: \_\_\_\_\_

Has anyone in your family been diagnosed with any of the following conditions? If yes, please indicate relation.

Relation

Glaucoma  No  Yes: \_\_\_\_\_

Macular degeneration  No  Yes: \_\_\_\_\_

Retinal detachment  No  Yes: \_\_\_\_\_

## MEDICAL HISTORY

Have you been diagnosed with any of the following conditions?

High Blood Pressure  No  Yes

Heart Disease  No  Yes

High Cholesterol  No  Yes

Stroke  No  Yes

Diabetes  No  Yes

Arthritis  No  Yes

Please list any other medical conditions: \_\_\_\_\_

Please continue on reverse side.

**MEDICAL HISTORY CONTINUED**

Have you ever been hospitalized or had surgery?  No  Yes If yes, please explain: \_\_\_\_\_

Please list any medications you take, prescription and non-prescription. Include dosages if possible: \_\_\_\_\_

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

Do you have other allergies (food, latex, etc.)?  No  Yes If yes, please list: \_\_\_\_\_

Are you currently pregnant?  No  Yes Nursing?  No  Yes

**Review of Systems**

Are you currently experiencing problems with any of the following? If yes, please explain.

- Sudden weight gain or loss  No  Yes: \_\_\_\_\_
- Chronic fever or chronic fatigue  No  Yes: \_\_\_\_\_
- Heart (chest pain, irregular heart beat)  No  Yes: \_\_\_\_\_
- Respiratory (coughing, shortness of breath, asthma)  No  Yes: \_\_\_\_\_
- Ear/Nose/Throat (sinus problems, hearing loss, sore throat, ear ache)  No  Yes: \_\_\_\_\_
- Gastrointestinal (abdominal pain, heart burn, bowel problems)  No  Yes: \_\_\_\_\_
- Hematologic/Lymphatic (blood disorders, enlarged glands)  No  Yes: \_\_\_\_\_
- Endocrine (thyroid, diabetes)  No  Yes: \_\_\_\_\_
- Integumentary (rashes, dry skin)  No  Yes: \_\_\_\_\_
- Musculoskeletal (joint or muscle pain, weakness, bone loss)  No  Yes: \_\_\_\_\_
- Neurological (headache, migraines, seizures, paralysis)  No  Yes: \_\_\_\_\_
- Psychiatric (depression, anxiety, ADD/ADHD, insomnia)  No  Yes: \_\_\_\_\_
- Allergic (reaction to food or drugs, seasonal allergies)  No  Yes: \_\_\_\_\_
- Immunologic (rheumatoid arthritis, lupus, multiple sclerosis)  No  Yes: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Has anyone in your family been diagnosed with any of the following conditions? If yes, please indicate relation.

	Relation		Relation
High Blood Pressure	<input type="radio"/> No <input type="radio"/> Yes: _____	Heart Disease	<input type="radio"/> No <input type="radio"/> Yes: _____
High Cholesterol	<input type="radio"/> No <input type="radio"/> Yes: _____	Stroke	<input type="radio"/> No <input type="radio"/> Yes: _____
Diabetes	<input type="radio"/> No <input type="radio"/> Yes: _____	Arthritis	<input type="radio"/> No <input type="radio"/> Yes: _____
Other: _____			

**SOCIAL HISTORY**

Use of Alcohol:  Never  Rarely  Moderately  Daily: \_\_\_\_\_ drinks/day

Use of Tobacco:  Never  Previously, but not in past \_\_\_\_\_ years  Yes: \_\_\_\_\_ packs/day

To the best of my knowledge, I completed this form accurately. I understand that it is my responsibility to inform my doctor of any changes in my health/medical status.

\_\_\_\_\_  
Signature of Patient (or Guardian)

Date: \_\_\_\_\_

## Optomap® Retinal Imaging

Our doctors want **all** patients to have Optomap® retinal imaging performed each year. A comprehensive eye exam includes a thorough retinal evaluation. Optomap® retinal imaging will be done annually unless a waiver is signed. The fee is **only \$28**. This is **significantly** less than the fees charged by other offices in the area. It is not covered by insurance.

This state-of-the-art scanning digital technology enables your doctor to examine your retina without dilating your pupils. A thorough examination allows for early detection of glaucoma, macular degeneration, diabetic retinopathy, hypertension and ocular melanoma. These conditions typically have no associated symptoms.

Advantages of Optomap® retinal imaging:

- An ultra-wide view of your retina that your doctor will review with you
- Does not require pupil dilation so you can resume normal activities immediately (Dilation causes blurry distance and near vision, as well as light sensitivity for 6 to 8 hours.)
- Provides permanent records for future comparison
- Quick, comfortable, non-invasive and completely safe
- Decreases the amount of time spent waiting in the office

Please Initial: \_\_\_\_\_

## OAK HILL EYE CARE PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies please discuss them with our of our front office staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MASTERCARD AND DISCOVER.

### Your Insurance

- We have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a signed contract, we will be happy to prepare a claim for you to file on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

### Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

### No-Shows

- Due to high patient demand and the limited availability of appointments, no-shows will result in a **fee of \$30**.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.**

**Printed Patient Name:** \_\_\_\_\_

**Patient Signature (or Responsible Party if Minor):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*\*TO BE COMPLETED BY CONTACT LENS PATIENTS ONLY\*\***

**Oak Hill Eye Care Annual Contact Lens Agreement**

Please review the following points regarding your contact lens care and sign below to indicate that you read and understand the terms of the agreement.

- The fitting and/or evaluation of contact lenses is performed *in addition to* a general eye exam. The fee for this service varies based on the type of contact lenses prescribed by your doctor.
- Because contact lenses are medical devices, Texas law requires an annual contact lens evaluation in order to renew your contact lens prescription. This applies even if there is no change in prescription. More frequent evaluations may be needed for patients with certain ocular conditions.
- It is important to wear sunglasses over your contact lenses because UV light causes cataracts, macular degeneration and pingueculae (tissue growth on the white part of the eye). Please ask one of our opticians about specials on non-prescription sunglasses for contact lens wearers.
- Back-up glasses in the correct prescription are needed in case of infection and so that you are able to take regular breaks from contacts lens wear. Please ask one of our opticians about specials on back-up glasses for contact lens wearers.
- Contact lenses may be returned for credit within 30 days of original purchase. Boxes of contact lenses must be re-sellable (unopened and free of markings).
- Because many contact lenses are not kept in stock and sometimes even trial lenses need to be ordered, it is best not to wait until you are completely out of lenses to re-order or make an appointment with us.
- There is an increased risk of infection or corneal ulcers that can cause vision loss with contact lens wear. This risk increases if contacts are worn overnight.
- While some contacts are approved for extended/overnight wear, always discuss this option with your doctor before sleeping with your lenses in. Not all patients are good candidates for this wear schedule and not all contacts are FDA-approved for overnight wear.
- If you purchase a one-year supply of contacts, we will ship them to you at no charge. If you order less than a one year supply, you may be responsible for any shipping fees.
- Payment for contact lenses is due at the time of order.

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Signature

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Date