Harrel. eyecare

WELCOME

Thank you for choosing our office for your eyecare needs! We're glad to help if you have questions.

All Patient Information is Confidential

Mr. Mrs. Ms. Dr. Name: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Text OK?: _____

Email: _____ Birthdate: _____

Patient's SSN: _____ Occupation: _____

Height: _____ Weight: _____

❒ Male ❒ Female Marital Status: ❒ Single ❒ Married

Preferred Method of Communication: ❒ Text ❒ Email ❒ Cell Phone ❒ Home Phone

Preferred Language: ❒ English ❒ Spanish ❒ Other: _____

Race: (optional)
❒ American Indian or Alaskan Native
❒ Black or African American
❒ Native Hawaiian or Pacific Islander
❒ Asian
❒ Hispanic
❒ White

Primary Physician/Pediatrician: _____

Preferred Pharmacy: _____

Insurance Information

If you are using insurance, we need to copy your medical and vision cards if you have one. We provide treatment for both medical eye conditions as well as comprehensive vision care. Thank you.

Primary Member's Name: _____ Primary Member's Employer: _____

Primary's social security #: _____ Primary Member's Birthdate: _____

Please Fill Out Both Sides

Your Eye Health and Vision are important to us.

Health History

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	❒	❒	Glaucoma	❒	❒
High Blood Pressure	❒	❒	Cataracts	❒	❒
High Cholesterol	❒	❒	Turned Eye	❒	❒
Heart Disease	❒	❒	Lazy Eye	❒	❒
Kidney Disease	❒	❒	Eye Injury	❒	❒
Thyroid Disease	❒	❒	Eye Surgery	❒	❒
Asthma	❒	❒	Blindness	❒	❒
Cancer	❒	❒	Macular Degeneration	❒	❒

Other Systemic Conditions: _____

Please indicate if any of the following apply to you:

❒ Allergies ❒ Smoker

❒ Pregnant ❒ Frequent Headaches

Medications you are currently taking OR we can copy a list if you have one: ❒ None

_____

Please list medications you allergic to:

_____

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Please Sign Both the Privacy Practices & the Payment Information

Notice of Privacy Practice

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices (available at the front desk).

Patient Name (please print):_____Date: _____

Signature of Patient or Guardian:

_____

Payment Information

Payment Information – Please read and sign below. Thank you.

1. I authorize you to bill my insurance for any applicable services or products.

2. I understand that payments for non-insured services are **due the same day services are rendered .**

3. I understand if I have not met my health insurance deductible and I'm receiving medical eyecare that **50% of the bill is due today**, and any balance remaining after being processed through insurance will be billed to me.

Signature of Patient or Guardian:

_____Date:_____

We are glad to answer any questions regarding your insurance benefits. Thanks!

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Developmental Vision Checklist, please check any that apply:

- ❒ Slow reader
- ❒ Points with finger while reading
- ❒ Poor reading comprehension
- ❒ Poor handwriting skills
- ❒ Homework takes longer than it should
- ❒ Short attention span, restless, unable to stay on task
- ❒ Avoids close work
- ❒ Loses place, omits or confuses small words while reading
- ❒ Rubs eyes, squints or blinks excessively
- ❒ Smart in everything but school
- ❒ Has an Individual Education Plan (IEP)
- ❒ Resource Room for _____
- ❒ Tutor for _____
- ❒ Substitutes words while reading or copying
- ❒ Difficulty remembering what was read
- ❒ Headache after doing close work
- ❒ Confuses right with left directions repeatedly
- ❒ Feels unusually tired after finishing a visual task
- ❒ Fatigue, frustration, stress
- ❒ Unusual posture/head tilt while reading or writing
- ❒ Double vision
- ❒ Speech/Language Therapy
- ❒ Has repeated _____ grade
- ❒ Other: _____

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Optomap

Early signs of disease in the periphery of your retina can remain undetected when using traditional methods. The Optomap image is a unique technology that allows us to scan 80% of your retina in one panoramic image, without dilation. For this reason, our doctors strongly recommend that all patients have the Optomap procedure performed annually.

Optomap benefits:

- Allows our doctors to track your complete eye health for concerns.
- Facilitates early protection from vision impairment or blindness.
- Early detection of retinal disease more effectively and efficiently.
- Early detection is essential to reduce the risk to your sight and health.

Please check one of the following:

___ I choose to have the Optomap scan. I understand that based on the doctor's assessment of the retinal scan and examination, dilation may still be recommended. I understand there is a $25.00 fee for this scan.

OR

___ I choose to be dilated today. I understand that after dilation, my vision may be slightly blurry when reading and might be light sensitive for 3-4 hours.

Print Patient Name:_____

Signature of Patient/Guardian:_____ Date:_____

Relationship to Patient (if signed by someone other then patient):_____