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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Thank you for answering these questions about your eyes to help us serve you better.

Do you currently wear glasses? ☐ Yes ☐ No
If yes: ☐ Full Time ☐ Reading/Near work Other:_____

Are you planning on getting new glasses today? ☐ Yes ☐ No ☐ Unsure
If yes:
☐ Everyday glasses ☐ Computer glasses ☐ Reading glasses ☐ RX Sunglasses
☐ TV glasses ☐ Driving glasses ☐ RX Sports glasses ☐ RX Safety glasses

Do you wear contact lenses?	☐ Yes	☐ No	
Are you renewing your contact lens prescription today?	☐ Yes	☐ No	☐ Unsure
Do you have difficulty seeing at night?	☐ Yes	☐ No	
Do you wear anything to protect your eyes from the sun?	☐ Yes	☐ No	
Do you use a computer/phone/tablet over 4 hours daily?	☐ Yes	☐ No	

Do you ever experience:

Gritty or sandy sensation?	☐ Never	☐ Sometimes	☐ Frequently
Itchy eyes?	☐ Never	☐ Sometimes	☐ Frequently
Itchy eyelids?	☐ Never	☐ Sometimes	☐ Frequently
Fluctuating vision?	☐ Never	☐ Sometimes	☐ Frequently
Eye pain or soreness?	☐ Never	☐ Sometimes	☐ Frequently

For office use only, options and recommendations:
☐ Everyday glasses ☐ Computer glasses ☐ Reading glasses ☐ RX Sunglasses
☐ TV glasses ☐ Driving glasses ☐ RX Sports glasses ☐ RX Safety glasses

☐ Anti-glare ☐ Blue-light AR ☐ Transitions ☐ Polarized ☐ SV ☐ PAL ☐ BF

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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):_____

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Consent to disclose medical and payment information

Patient Name: _____ Date of Birth: _____

Please CHECK one of the following:

_____ I give my permission to Harrel Eyecare doctors to disclose my Protected Health Information or payment to me AND the following friends or family:

NAME: _____RELATION: _____

NAME: _____RELATION: _____

NAME: _____RELATION: _____

NAME: _____RELATION: _____

OR

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other friends or family.

_____ _____

Signature of patient or guardian Date

_____

Relation if not signed by patient