2020 Vision Care

www.2020vision-care.com

PATIENT INFORMATION

Melissa R. Lewis, O.D.

Prefix: Mr. Mrs. Miss Ms. Dr.		**Today's Date** / /	
Patient's Name: First	Middle	Last	
Preferred Name:			
Address: Street & Apt. #	City	State	Zip
Last 4 Digits of SS#:	**Birthdate:** / /	**Age:**	**Sex:** ☐ Female ☐ Male
Home Phone:	**Cell Phone:**	**Work Phone:**	
Do we have permission to text you to remind you of appointments or to let you know that your eyeglasses or contacts have arrived? YES ☐ NO ☐			
E-Mail Address:	**May we e-mail You?** YES ☐ NO ☐		
Patient's Employer:	**Occupation:**		
Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name_____			
Whom may we think for referring you? ☐ Family/Friend ☐ Insurance ☐ Internet ☐ Other_____			
Other family members seen here:			

INSURANCE INFORMATION

(Please give your insurance card to the reception desk)

Primary MEDICAL Insurance:	**ID#**
Subscriber's Name	**Subscriber's Birthdate** ___/___/____
Relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Primary VISION Insurance:	**ID#**
Subscriber's Name	**Subscriber's Birthdate** ___/___/____
Relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	

MEDICAL HISTORY

Primary Care Physician:	Where are they located?
What is the reason for your examination today?_____	

Patient Ocular History:		
☐ Cataract	☐ Blurred Vision	☐ Sandy/Gritty Feeling
☐ Macular Degeneration	☐ Eye Surgery	☐ Light Sensitivity
☐ Glaucoma	☐ Drooping Eyelid	☐ Eye Injury
☐ Dryness	☐ Mucous Discharge	☐ Redness
☐ Flashes Of Light	☐ Foreign Body Sensation	☐ Eye Pain
☐ Floaters/Black Spots	☐ Watering	☐ Burning
☐ Retinal Disease	☐ Itching	☐ Lazy/Crossed Eye
Please Check All That Apply:		
☐ Weight Loss/Gain	☐ Stroke	☐ Rosacea
☐ Cancer	☐ Heart Disease	☐ Diabetes
☐ Hearing Loss	☐ Asthma	☐ Thyroid Problems
☐ Multiple Sclerosis	☐ Emphysema/COPD	☐ High Cholesterol
☐ Autism Spectrum	☐ Sleep Apnea	☐ Allergies
☐ Anxiety/Depression	☐ Acid Reflux	☐ Rheumatoid Arthritis
☐ Attention Deficit	☐ Pregnant/ Nursing	☐ Other_____
☐ High Blood Pressure	☐ Arthritis	

Are you pregnant or nursing? ☐ Yes ☐ No	**Do you drive?** ☐ Yes ☐ No
List all prescription medications you currently take:_____	
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:_____	
Do you drink alcohol? ☐ Yes ☐ No ___ Social ___ 1-2 Drinks Daily ___Above Average Use ___Dependence	
Do you smoke or use tobacco? ☐ Yes ☐ No ____Less than 1 pack a day ___1-2 Packs a day ___ 2 Packs a day	

Family History (Parents, Grandparents, Siblings, Children) Please indicate which family member.

☐ Lazy/Cross Eyes _____	☐ Diabetes _____	☐ Cataracts_____
☐ Retinal Detachment _____	☐ Macular Degeneration _____	☐ Glaucoma _____
Name of your last eye doctor (If not Dr. Lewis):_____		**Last Exam:**_____
Do you wear glasses? ☐ Yes ☐ No	**If yes, how old is your current pair?**_____	
Do you wear contacts? ☐ Yes ☐ No	**Are you interested in being examined for contact lenses**	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize 20/20 Vision Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature_____ **Date** ___/___/____

Revised 11/15/2016

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Optos Retinal Image

Your doctor recommends the Optomap Retinal Exam as part of your eye examination today. The Optomap ultra-wide digital retinal imaging system captures more than 80% of your retina in one panoramic image while creating a permanent record of your eye health. Traditional methods typically reveal only 10-15% of your retina at one time. With this enhanced ability to view your retina digitally, it may not be necessary to dilate your pupils today.

There is an additional fee of $35 for this test which most insurance companies do not cover.

☐ **Yes, I DO want the Optos Retinal Image.**

HIPAA

The HIPPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide at least one individual with whom we may share your medical records.

Authorized Individual _____ **Phone Number**_____

Statement of Financial Responsibility

In order for my eyecare provider 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. I authorize the release of my information for my eyecare provider to file all claims if we are a participating provider for your plan. However, if my insurance denies payment for any claims submitted, I will be responsible for full payment. Otherwise, my eyecare provider will supply me with an itemized statement which I may submit to my insurance carrier.

☐ **I have read and understand the Statement of Financial Responsibility**

Signature of Patient (or Parent/Guardian) _____