Welcome to Grove City Eye Associates

<u>Patient Information</u>

Title: ____ **Last Name**: ______________________________________ **First Name**: _________________________ **MI**: ____

Preferred Name: ______________________________ **Date of Birth**: _________________________ **Sex**: **M / F**

Marital Status: **<u>Annulled</u>** **<u>Divorced</u>** **<u>Domestic Partner</u>** **<u>Legally Separated</u>** **<u>Married</u>** **<u>Never Married</u>** **<u>Polygamous</u>** **<u>Widowed</u>**

Address: ____

City: ____ **State**: ________ **Zip Code**: ________________

Home Phone: _______________ **Cell Phone**: _______________ **E-Mail**: ____

Preferred Contact (Please Circle): **Home Phone** **Cell Phone** **Text Message** **E-Mail**

Please circle preferred language, race, and ethnicity below:

Language: **English** **Spanish** **French** **Other: ____**

Race: **American Indian/Alaskan Native** **Asian** **Black** **Native Hawaiian/Pacific Islander** **White** **Other**

Ethnicity: **Hispanic** **Non-Hispanic** **Unknown**

Occupation: **_________________________________Employer:____**

<u>If the above patient is a minor under the age of 18, please fill out the following</u>:

Name of Parent/Guardian: ____ **Date of Birth:** ____________________

Consent Given For: **Exam – Yes No** **Contact Lens Fitting – Yes No** **Dilation Drops – Yes No**

Signature: ____ **Relationship:** ____________________

Parent or Guardian MUST be present when presenting this document to the office.

Please present all vision & medical insurance cards at the time of visit. Sometimes a medical condition is detected during the vision exam and we may be able to bill your medical insurance for any additional procedures or follow-up visits. Medical visits are not billed the same as routine vision exams. The fee is based on the complexity of the medical condition and the procedures required for diagnosing, and managing the condition.

If you will <u>NOT</u> be using any vision or medical insurance, please check the self pay box below, sign, and date.

Self Pay **Signature: ____Date: __________________________**

Coordination of Insurance Benefits

Main Policy

Insurance Company:		Policy Holder:	
Insurance ID:		SSN:	
Through Employer:	Yes No	Date of Birth:	
Employer Name:			
Coverage Type:	Medical Vision Dental Other		
Policy Holder Address:			
City/State/Zip:			
Policy Holder Phone:			

Secondary Policy

Insurance Company:		Policy Holder:	
Insurance ID:		SSN:	
Through Employer:	Yes No	Date of Birth:	
Coverage Type:	Medical Vision Dental Other		
Policy Holder Address:			
City/State/Zip:			
Policy Holder Phone:			

Please check box if no secondary insurance.	

Tertiary Policy

Insurance Company:		Policy Holder:	
Insurance ID:		SSN:	
Through Employer:	Yes No	Date of Birth:	
Coverage Type:	Medical Vision Dental Other		
Policy Holder Address:			
City/State/Zip:			
Policy Holder Phone:			

Please check box if no tertiary insurance.	

For Office Use Only:
Insurance verified by: **Date:**

Patient Ocular History — Please check all that apply or None

- ❑ Cross Eye/Lazy Eye
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Retinal/Macular Disease
- ❑ Eye Injury
- ❑ Flashers/Floaters
- ❑ Double Vision
- ❑ Loss of Side Vision
- ❑ Blurry Vision
- ❑ Dryness/Stinging/Burning
- ❑ Itching/Redness
- ❑ Watering
- ❑ Eye Strain
- ❑ Glare/Light Sensitivity

Eye Surgeries: ________________________ None Eye Medications: ______________________________ None
Date of Last Eye Exam: __________________________ Doctor: ____
Do you currently wear contact lenses? Yes / No Interested in contacts today? Yes / No
Type of Contact Lenses: _____________________________ Age of Current Contacts: _____________________________

Patient Medical History — Please circle all that apply or None

Constitutional: currently pregnant/nursing, fatigue, weight loss/gain, none
ENT: allergies, sinus problems, cough, dry throat/mouth, hard of hearing, none
Cardiovascular: high BP, surgery, vascular disease, heart attack, none
Respiratory: asthma, bronchitis, COPD, emphysema, sleep apnea, none
GI: diarrhea, constipation, ulcers, none
Genitourinary: abnormal urination, impotence, kidney disease, none
Osteoskeletal: joint pain, arthritis, none
Integumentary: growths, rash, acne, none
Neurological: headaches, seizures, dizziness, numbness, dementia, none
Psychiatric: anxiety, depression, insomnia, none
Endocrine: diabetes, hypothyroid, hyperthyroid, none
Blood: anemia, high cholesterol, none
Immunological: lupus, HIV, AIDs, rheumatoid arthritis, none

Other: ____

Injuries/Surgeries/Hospitalizations: ____ None

Drug Allergies: ____ None

Primary Care Doctor: ____ Phone Number: __________________________

Preferred Pharmacy: ____ Location: ____________________________

Medications/Vitamins/Herbal Supplements: ____ None

____

Family History — Please circle all that apply or check NONE — None — Adopted or Unknown

Ocular: glaucoma, cataracts, macular degeneration, retinal disease, lazy eye
Family Member(s): ____

Medical: diabetes, cancer, high blood pressure, heart disease, arthritis, kidney disease, lupus, thyroid
Family Member(s): ____

Social History — Please circle all that apply

Smoking Status: Never Former Current – Daily – Light (<10) – Heavy (>10) Current – Occasionally
Alcohol Use: Daily Socially None
Illegal Drugs: Yes No

Authorization & Financial Responsibility/Notice of Privacy Practices

Insurance Authorization and Assignment: I request that payment of any insurance or vision plan benefits be paid on my behalf to Grove City Eye Associates, LLC for any furnished services. I authorize any holder of medical information about me to release any information needed to process my insurance or vision claim.

About Your Insurance: There are two types of health insurance that will help pay for your eye care services: Vision care plans and medical insurance. You have both and our practice accepts both.

- Vision plans only cover routine vision exams and only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical Insurance must be used if you have any eye health problem or systemic health problem that has ocular complications.
- All insurance claim submissions, including vision plans, are billed using medical codes and may differ from the discounted routine exam fee paid, in-full, at the time of service for those without insurance or a vision plan.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out of pocket expenses.

All Services Are The Responsibility Of The Patient: Having insurance is not a substitute for payment. We can only bill your insurance plan for services if we are participation provider for that plan. I understand that insurance benefits must be determined prior to my exam. We will assist you in receiving reimbursement as much as possible, but you are responsible for you bill. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract. I understand that I am financially responsible for any non-covered services and any unpaid insurance balance over 45 days past due. If I become aware of insurance coverage after services have been rendered I agree to personally submit the claim to my insurance company for reimbursement.

Returned Checks: There is a $30.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Notice of Privacy Practices: A copy of our Notice of Privacy Practices is available detailing how we will handle your private medical information and records. By signing below, you acknowledge that you have been offered a copy of Grove City Eye Associates, LLC's Notice of Privacy Practices.

- ❑ Yes, I would like a copy of the Notice of Privacy Practices.
- ❑ No, I do not wish to receive a copy of the Notice of Privacy Practices.

By signing this statement you agree to be financially responsible for all charges. This assignment will remain in effect until revoked in writing. A photocopy of this authorization is considered to be as valid as the original.

X: ____ Date:______________