Patient information **Today's Date ___/___/___**

Last Name: _____ **First:** _____ **M.I.**_____

Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Date of Birth: __/__/__ **Cell Phone:** ( ) _____ **Alternate Phone:** ( ) _____

Email:_____ **Marital Status: Single / Married / Other**

Occupation: _____ **Employer:** _____

Preferred Pharmacy: _____

Address: _____ **Phone:** ( ) _____

Do you have the following **Medical Insurance? AETNA / BLUE CROSS / CIGNA / OXFORD / UNITED HEALTHCARE**

If yes, who is the primary insured on this plan? **SELF / SPOUSE / PARENT / OTHER**

If not yourself: **Name of primary insured:** _____ **Their Date of Birth:** ___/___/___

Your **Vision Plan** (if any): **EYEMED / HUMANA / VSP Last 4 Digits of Primary Member SS#:** ____

PLEASE PROVIDE PICTURE ID AND ALL INSURANCE CARDS ALONG WITH THIS FORM

HIPAA/ ACKNOWLEDGEMENT OF RECEIPT

This is to notify you that any information you provide us and any information created in the course of providing services to you will only be disclosed or used for the purposes of treatment and care to conduct healthcare operations in our office. I acknowledge that I have been offered and/or given a copy of the Office's Notice of Privacy Practices.

Patient (Parent/Guardian) **Signature:** _____ **Date:**_____

SIGNATURE ON FILE / RELEASE OF INFO / ASSIGNMENT OF BENEFITS

I authorize the release of the above information to my insurance carrier(s) in order to determine the benefits payable for services rendered. I authorize the doctors in this office to act on my behalf in obtaining payment from my insurance company and that these benefits be made payable to them. *I understand that I am responsible for any co-pays, deductibles that have not yet been met and charges not covered by my insurance.* This serves as a lifetime signature on file form solely for the purposes stated above.

Patient (Parent/Guardian) **Signature:** _____ **Date:** _____

NOTE: If we do not accept your insurance, you are responsible for full payment for services provided by this office. *Professional service fees are not refundable.* We recommend you check with your insurance carrier prior to your eye exam to determine if they will reimburse you for out of network expenses. Please be advised that **Spectacle follow ups are included within the first 90days** of initial exam date and **contact lenses follow ups are included within the first 60 days, additional fees will apply for anything after.** If Dilation can not be performed at the time of service you will have 7 days from the original exam date to complete the exam.
Our office requires payment at the time of service. If you have a medical ocular condition, your medical insurance information will be required for billing purposes. You are responsible if your insurance does not cover any services. Contact Lens evaluations are billed separately from your eye exam.

PLEASE SEE REVERSE

Last Name _____ First Name _____ Date _____

REVIEW OF SYSTEMS: Do you have any medical problems involving the following areas?
(Please circle YES or NO and describe if any.)

Respiratory.....Y N _____
Skin/Dermatologic.....Y N _____
Ear, Nose, Throat.....Y N _____
Allergic/Immune System.....Y N _____
Thyroid/Other Glands.....Y N _____
Gastrointestinal/Liver.....Y N _____
Genitourinary.....Y N _____
Neurological .....Y N _____
Lymph Nodes/Blood Disorders.....Y N _____
Fever/Weight Loss or Gain.....Y N _____
Bones, Muscles, Joints.....Y N _____
Psychiatric.....Y N _____

Do you smoke? Y / N If yes, how much? _____
Drink alcohol? Y / N If yes, how many drinks per week? _____

Do **you or blood relatives** have any of the following health problems?**(If yes, please specify SELF or FAMILY)**
high blood pressure / diabetes / heart problems / stroke / cancer / NONE
*Explain if needed:*_____

What medications/vitamins (if any) are you currently taking? _____

Are you **allergic** to any medications or eye drops? _____Y N

Are you currently pregnant or nursing? _____Y N

.....

Do **you or blood relatives** have any of the following eye conditions?**(If yes, please specify SELF or FAMILY)**
glaucoma / macular degeneration / retinal disease / corneal disease / NONE
*Other:*_____

Have you ever had an eye injury, eye surgery, or other serious eye problem?
*Explain:*_____

Do you suffer from Dry Eye or was previously diagnosed with Dry Eye? Y N

Do you see flashes of light or floating spots? _____ Y N

Do you have severe/frequent headaches or eye pain? _____ Y N

When was the last time you had your eyes **dilated**? _____

.....

Do you CURRENTLY wear contact lenses? _____ Y N
Are you here for a contact lens fit & evaluation today?**(See Note Below)**_____ Y N

***If you wear contacts, an annual contact lens evaluation is **medically necessary**. Along with updating your prescription, the doctor will check the health of the eyes, curvature of the cornea, inspect the eye for microscopic complications, abnormal blood vessel growth related to wearing contacts and evaluate the fit of the contacts on the eyes every visit.
REMEMBER CONTACT LENSES ARE MEDICAL DEVICES.

cosmopolitan eyecare

The Dilation exam times are available **ONLY** during the following hours:

- Monday/Wednesday/Friday: 9:00 AM - 11:00 AM, then 2:30 PM - 4:00 PM
- Tuesday/Thursday: 10:00 AM - 11:00 AM, then 2:30 PM - 4:00 PM
- Saturday: 10:00 AM – 2:00 PM
- Sunday: 11:00 AM – 2:00 PM

The Appointment times are subject to availability and limited by our Office hours. There is a **30 DAY GRACE PERIOD** for Dilation exams from the initial date of service.

The retina evaluation may have insurance coverage limited to the same day service. I understand that if I choose to defer the retina evaluation, I take responsibility for any conditions that may otherwise be undetected. If a condition arises in the future which may have been detected by retina evaluation, I will not hold the Doctor and her staff responsible.

Please sign below to acknowledge the office policy and responsibilities.

_____	_____	____/____/____
Printed Name	Signature	Date

***For your convenience, we have the option of a comprehensive exam with the OPTOMap and iWellness technology that may be discounted with your insurance. Your technician will discuss the options and copayments during prescreening.

For the Contact Lens Patient:

Contact lenses are medical devices that can only be dispensed by prescription. They are treated with the same caution used for prescriptive drugs, as contact lenses are *medical devices*. They will have expiration dates and follow up visits (limited to 2 months from the date of exam). Your eyes go through gradual changes in size, shape, and physiology over time that can affect the fit of the lenses and health of your eyes. For this reason, contact lens evaluations are required annually under **Federal Law**.

Please sign below to acknowledge the office policy and responsibilities.

_____	_____	____/____/____
Printed Name	Signature	Date