EDWARDS EYE CARE

Patient History Form:

Name (First)_____ (Ml)_____ (Last)_____Gender: M / F
Address_____ City_____ State _____ Zip_____
Telephone (H): _____(Cell/Work): _____ DOB: ___/___/_____ Last 4 SS# _____
Preferred Contact Number: Home/Cell Occupation _____ Employer: _____
☐Single ☐ Married Email: _____
Health Insurance _____ID: _____ Vision Insurance _____ID:_____
Primary Last 4 SS#: _____ Last Medical Exam: _____ Last Eye Examination: _____
What pharmacy do you use? _____
Who may we thank for your referral? _____

EYE CONDITIONS THAT APPLY TO YOU: **( ) NONE** **( ) Cataract Surgery** **( ) LASIK**

( ) Cataracts	( ) Diabetes	( ) Dry Eyes	( ) Floaters / Flashes of Light
( ) Macular Degeneration	( ) Retinopathy	( ) Eye Infection	( ) Retinal defects
( ) Glaucoma			( ) Other

EYE CONCERNS THAT APPLY TO YOU: **( ) NONE**

( ) Redness	( ) Itching	( ) Discharge
( ) Burning	( ) Tearing	( ) Other

REASON FOR TODAY'S EXAM AND VISION CONCERNS THAT APPLY TO YOU:

( ) Annual Eye Exam	( ) Eye Pain	( ) Night Glare
( ) Blurry Vision	( ) Sensitive to light	( ) Double Vision
( ) Eye Strain	( ) Headaches	( ) Other

CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU ( ) NONE

( ) Diabetes Type 1 / Type 2	( ) Vascular Disease/Stroke	( ) Cancer	( ) Skin/Eczema/Psoriasis
( ) High Blood Pressure	( ) Seizures	( ) Thyroid Hypo / Hyper	( ) Kidney/Bladder
( ) High Cholesterol	( ) Lung Disease/Asthma	( ) Arthritis	( ) Psychiatric
( ) Heart Disease	( ) Migraines	( ) Autoimmune	

CURRENT MEDICATIONS: ( ) NONE ( ) YES, please list

_____

Including prescription, over the counter, vitamins, natural herbs, and birth control. Use space below if needed

ALLERGIES TO MEDICATIONS: ( ) NONE ( ) YES, please list ( ) Latex ( ) Seasonal

_____

DO YOU: DRINK ALCOHOL ( ) YES ( ) NO USE TOBACO PRODUCTS ( ) YES ( ) NO

CHECK ANY CONDITIONS PRESENT IN FAMILY MEMBERS AND WHOM ( ) NONE

( ) Glaucoma_____	( ) Retinal Detachment _____	( ) Blindness _____	( ) Cancer _____
( ) Cataracts _____	( ) Turned/Crossed Eye _____	( ) Diabetes Type 1 / Type 2 _____	( ) Heart Disease _____
( ) Macular Degeneration_____	( ) Lazy Eye _____	( ) High Blood Pressure_____	( ) Thyroid Disease _____

CORRECTIVE LENS HISTORY ( ) I don't wear any correction

I wear glasses: ( ) distance ( ) computer ( ) reading ( ) progressive

( ) I wear contact lenses: Brand _____ Do you sleep in your lenses Y or N Solution used:_____

Wear schedule: days per week _____ hours per day _____ Replacement (Circle): Daily 2 Weeks Monthly Quarterly Yearly

EDWARDS EYE CARE

VISION coverage is mainly designed to cover a routine evaluation of the eye (in a healthy patient that has no particular problem or symptom), a prescription for glasses, and to help pay for glasses or contact lenses.

When a MEDICAL condition is present that affects your eyes, such as high blood pressure, high cholesterol, diabetes, etc, or you have an eye disease/problem such as an infection (pink eye), dry eyes, allergy, cataracts, and more, we must often file the claim with your medical insurance; co-pays and deductibles for that particular medical insurance plan will apply.

In most cases, there is no way to know prior to your examination which type of insurance our office will be able to file for you. We make every effort to be a provider on most major carriers for your convenience. If we are not in network, we will provide you with an itemized receipt that you can submit. Insurance coverage is a contract between you and your insurance company, not Edwards Eye Care. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you

I understand the paragraphs above and authorize Edwards Eye Care to file my insurance by the above guidelines.

Signature_____ **Date:** _____

OFFICE POLICIES AND WARRANTY INFORMATION

EYEGLASSES

- One year warranty on manufacturer defect at 100% off. One time replacement only. Other damages are subject to manufacturer approval and may not be covered for full replacement.
- If you are not completely satisfied with your frame, we may be able to restyle you in a more suitable frame for a restyle fee of $50 within 30 days. Frames must be in resale condition and show no sign of wear. There is no warranty on lost or stolen frames.
- Within 90 days of exam, we are able to remake lenses for the following reasons: Doctor's prescription change, non-adapt of progressive lenses.

CONTACT LENSES

- Contact lens products may be exchanged within 90 days of purchase and are subject to a restocking fee of $5 per box. In order to exchange contacts, the boxes must be unopened with no markings or other package alterations on them.

PAYMENT DUE AT TIME OF SERVICE

- Payment due at the time services are rendered
- Any services not covered by your insurance company will be the responsibility of the patient

Receipt of Notice of Privacy Policies (HIPPA), Office Policies and Warranty Information
I acknowledge that I have read the Notice of Privacy Practices (HIPPA), and the Office Policies and Warranty Information from Edwards Eye Care. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company. I also understand that the premises are under video surveillance, and that these recordings will be kept strictly confidential. Edwards Eye Care may use them in any way deemed necessary, including use by law enforcement and in a court of law.

I acknowledge that I was given access to all of my prescriptions from today's visit including medicine prescriptions, glasses prescriptions, and contact lens prescriptions. I acknowledge that I will always have access to my prescriptions through my doctor, including paper copies when requested and through online access twenty-four hours a day, seven days a week.

Please sign below acknowledging that you understand:

Print Name: _____

If under 18, Name of Parent/Guardian:_____

Signature: _____ **Date:** _____

PLEASE LIST SOMEONE AS YOUR EMERGENCY CONTACT AND WHOM WE CAN SHARE YOUR MEDICAL INFORMATION. IF YOU PREFER NOT TO LIST ANYONE, PLEASE WRITE IN "N/A".

Name: _____ **Relationship:** _____ **Phone:** _____