# WELCOME TO ALLEN VISION CENTER
# Edward H. Topfer, O.D.

**We are delighted to have you as a patient. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate.**

**Preferred Method of payment (please circle)** **CASH** **CHECK** **DEBIT / CREDIT**

Gender Ethnicity _____ Race _____ Preferred Language _____

**Patient Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

*DOB* *First Name* *Last Name* *Nickname*

*AGE* *Street Address* *City* *State* *Zip*

*Social Security Number* *Home Phone* *Cell Phone* *Email*

## Medical Insurance Information

| | | | | |
|---|---|---|---|---|
| *Company Name* | *Insured's Name* | *ID#* | Insured's SSN | *Insured's DOB* |

## Routine Vision Insurance Information

| | | | | |
|---|---|---|---|---|
| *Company Name* | *Insured's Name* | *ID#* | Insured's SSN | *Insured's DOB* |

**Who can we thank for referring you to our office?** (New Patients Only)

☐ Phone book ☐ School ☐ Patient (please name)_____

☐ Insurance listing ☐ Other_____ ☐ Doctor (please name)_____

☐ Internet Search Family Members seen by this office _____

Employment: (Circle Applicable)
Full Time
Part Time
Student (Full Time) (Part Time)
Unemployed
Retired

Substance Usage / Consumption: Frequency / Quantity
Tobacco Smoke (Please Circle One):
Current Every Day Current Some Days Former Smoker Never Smoked
Alcoholic Beverages: Y N _____

Employer:_____
Occupation:_____

Computer Usage (Hours Per Day): _____

Date of Last Eye Exam: _____ Name of Optometrist:_____
Name of Primary Care Physician _____

| | | | | |
|---|---|---|---|---|
| Currently Wearing Glasses | Y | N | Age of Glasses: _____ | Seriously Interested in LASIK? Y N |
| Problems with Current RX? | Y | N | (If yes, elaborate)_____ | |
| Currently Wearing Contacts | Y | N | If applicable: Soft or Hard? | _____ |
| Interested in Wearing Contacts | Y | N | Solution Used | _____ |
| Sleep Wearing Contacts? | Y | N | Hours per Day Worn? | _____ |

Type of Lenses Worn (if known) _____

**LIST *ALL* MEDICATIONS:** **DOSAGE:** **FREQUENCY:** **ROUTE:**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

(USE BACK FOR MORE SPACE)

Medicinal Allergies: _____

**PLEASE *CIRCLE YES OR NO* TO EACH OF THE FOLLOWING:**

**HEALTH HISTORY (**Do you currently or have you ever had**)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Diabetes | Y N | Heart Pain | Y N | Thyroid or other glands | Y N | Allergies | Y N |
| High Cholesterol | Y N | Ears, Nose, Mouth Throat | Y N | Respiratory | Y N | Migraines | Y N |
| High Blood Pressure | Y N | Blood Disorders | Y N | Vascular Disease | Y N | Seizures | Y N |
| Gastrointestinal | Y N | Genitourinary | Y N | Bones or Muscles | Y N | Arthritis | Y N |
| Lymphatic | Y N | Psychiatric | Y N | Immunologic | Y N | | |

**EYES (Do you CURRENTLY have)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Floaters | Y N | Side Vision Loss | Y N | Infection of Eye | Y N | Dryness | Y N |
| Flashes | Y N | Double Vision | Y N | Other Eye Irritation | Y N | Discharge | Y N |
| Vision Blurred | Y N | Tearing / Watery Eyes | Y N | Headaches | Y N | Redness | Y N |

**PREVIOUS EYE HEALTH HISTORY**

Lazy Eye Y N Eye Surgeries (PAST) Surgical Date: _____

Cataracts Y N Eye Injuries (PAST) Date : _____

**EYE DISEASES** Y N

Please List: _____

**COMMUNICABLE OR AUTO-IMMUNE** Y N

Please List: _____

**LIST SURGERIES** – INCLUDE DATE OF SURGERY

_____

_____

_____

**FAMILY HISTORY**: Please **INDICATE FAMILY RELATION,** and if ***MATERNAL*** or ***PATERNAL*** side of the family***:***

| | | | | | |
|---|---|---|---|---|---|
| Blindness | Y N | _____ | Crossed Eyes | Y N | _____ |
| Glaucoma | Y N | _____ | Macular Degeneration | Y N | _____ |
| Retinal Detachment | Y N | _____ | Cataract | Y N | _____ |
| Retinal Disease | Y N | _____ | Diabetes | Y N | _____ |
| Other Eye Disease | Y N | _____ | | | |

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Allen Vision Center to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing. We require a 48 hour notice and a service charge of $25 per patient.

## PRIVATE HEALTH INFORMATION

My signature acknowledges that I was provided the opportunity to receive/review a copy of Child & Family Optometry's Privacy Policy Notice.

## FINANCIAL POLICY

**WE DO NOT BILL.** Payment for services rendered is due at the time of the initial examination.

As a courtesy, we will file your insurance with companies and plans we are in network with. If we are out of network, patient must pay in full and file themselves. **Quoted benefits are only an estimate. Benefits are subject to eligibility at the time of service**. **Any charges not covered by insurance will be the patient's responsibility**.

We will file Medicare claims for the patient, but the exam will still need to be paid in full at the time services are rendered. If your deductible has been met, Medicare will send you a reimbursement.

In instances where you have no insurance, payment for the examination and/or contact lens examination will be due at the time those services are rendered. In the event that you are ordering glasses we prefer full payment prior to our sending the order to our lab, but all we require is 50% at the time the order is placed and the remaining 50% at the time the order is picked up (unless you have insurance). Contact lens reorders totaling over $80 and all hard contact lens orders require payment prior to order placement.

In the event that you neglect to pay for services that are your responsibility, regardless the reason, we will report the situation to a credit-reporting agency. If we do report you to a credit-reporting agency, we will charge an additional 50% of your total amount due in order to cover the creditor's charges and still recover the amount for the usual and customary charges. If we pursue an outstanding balance through an attorney, you will be responsible for our attorney's fees and any other legal fees we encounter when trying to recover the debt. In the event of an **Insufficient Funds** check, a **NSF fee of $30** will be assessed.

As a result of our "no double booking" scheduling we have been successful in keeping patients from waiting for longer than an understandable amount of time; unfortunately the down side of this is when a patient does not call to cancel or just does not show. **Therefore, if you do not let us know of your need to cancel within 24 hours of the scheduled appointment time, we will bill you a $68 cancellation/no show charge.** This "No Show" fee may increase incrementally over time.

### PLEASE NO GUM CHEWING OR CELL PHONE USE DURING EXAM

Thank you for reading over the above. By signing below you acknowledge your receipt of this form, all information in this form is accurate and that you do fully understand and agree to abide by above.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Responsible Party | Printed Name of Responsible Party | Date |

# DIFFERENCE BETWEEN
# ROUTINE VISION INSURANCE AND MEDICAL EYE HEALTH INSURANCE

Often, patients have both routine vision and medical insurance. They are different in terms of the services they cover and it's important to understand those differences.

Routine vision insurance coverage (VSP, EyeMed, etc.) is designed mainly to determine a prescription for glasses or contacts, to help pay for glasses or contacts, and to cover routine screening of the health of the eyes in a healthy patient that has no particular eye health problems or symptoms.

When a medical condition is present such as diabetes, cataracts, floaters, eye irritations, etc., it is necessary to file the visit with major medical insurance (BCBS, Aetna, etc.). Medical insurance is designed for ***investigating the medical eye condition***, ***medical decision-making***, and ***counseling***, when you have a medical problem affecting the eyes, and not routine problems such as nearsightedness, farsightedness, and astigmatism. INSURANCE CARRIERS SET THESE RULES AND OUR OFFICE IS OBLIGED TO FOLLOW THEM.

I understand the above explanation concerning the difference between routine vision issues and medical issues, and authorize Allen Vision Center to file my insurance by the above guidelines. I understand I am responsible for payment of the corresponding co-pays or deductible amounts involved.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Printed Name | Date |