Welcome To River Valley Eye Clinic!

Our records indicate the following information. Please make and necessary changes.

Name:			
Address:	**City:**	**State:**	**Zip:**
Home:	**Work:**	**Cell:**	
Social Security:	**Date Of Birth:**	**Age:**	
Emergency Contact & Phone Number:			
Email Address:			
Marital Status: *If incorrect please check correct marital status:* Married ☐ Never Married ☐ Widowed ☐ Legally separated ☐ Divorced ☐			

Insurance Information

Company Name	Insurer's Name	ID #	Group #

☐ **I understand** I can request a copy of HIPAA Privacy Act at any time.

☐ **I understand** that it is my responsibility to give the current insurance information and demographic information. If the insurance provided is incorrect that it will be my responsibility to pay the balance.

☐ **I understand** in order to control the cost of billing, we ask the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs then be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to River Valley Eye Clinic. I understand that will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

☐ **I understand** I was given the opportunity to read River Valley Eye Clinic's notice of privacy practices in compliance with HIPAA standards, and declined. I wish to continue my care with River Valley Eye Clinic under the terms of River Valley Eye Clinic's privacy policies.

Signature: _____ **Date:** _____

PLEASE READ

I authorize the doctor to release any information including diagnosis, records of treatment or examinations rendered to me, my spouse or child during the period of such eye care to 3rd party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or group insurance benefits otherwise payable to me. I understand my insurance may pay less than the billed amount of services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.
CONSENT OF TREATMENT: I hereby grant **MY** authorization for medical treatment and procedures for myself and/or minor child and certify that no guarantee or assurance has been made as the results which may be obtained.

Dr. Reynoldson is committed to caring for our patient's ocular health. Our patients will receive a COMPLETE EYE HEALTH EXAMINATION. Our doctor is trained to diagnose and treat most ocular diseases. As a courtesy to our patients, we are happy to file with your insurance company. NOTE: the patient is responsible for any co-pays and/or deductibles which your insurance requires. **ROUTINE VISION EXAM** will be filled with patient's vision plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is Myopia (near sighted), Hyperopia (far sighted), Astigmatism, or Presbyopia. If a **MEDICAL DIAGNOSIS** (cataracts, glaucoma suspect, diabetes, pink eye, foreign body, etc) is determined by the doctor the patient's exam is no longer routine, but medical. This means we will bill your medical insurance. We request a copy of your medical card in your chart for that reason. I have read and understand when my **Vision Plan** will be billed and when my **Medical Insurance** will be billed by **RIVER VALLEY EYE CLINIC**.

PATIENT COMMUNICATION PREFERENCES (check if yes)

	May we call you here?	**May we leave message?**
HOME _____	☐	☐
CELL _____	☐	☐
WORK _____	☐	☐
OTHER? _____	☐	☐

Other than your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	Telephone
☐ Spouse	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

OPTOMAP RETINAL EXAM: Our doctor highly recommends that you have the Optomap Retinal Exam. The Optomap is a yearly comprehensive method of evaluating, monitoring, and helping treat various eye conditions.
You will not be dilated if you choose to have the Optomap done. There is a $30 charge, for this service.

Approve Optomap	**Want Further Information**	**Declined, I'd rather be dilated** (Against doctor recommendations)
☐	☐	☐

If all of the above information is correct and true please sign/date below:

SIGNATURE: **DATE:**

Main reason for your visit? _____

Other eye issues or problems?_____

I wear:

Glasses	☐ Full Time	☐ Part Time
Contacts	☐ Full Time	☐ Part Time

***Contact Lens Wearers Only**

Are your lenses comfortable?	Yes ☐	No ☐		
How old is your current pair?	1 week ☐	1 month ☐	Older ☐	
What brand of contacts do you wear?	_____			
What type of contacts do you wear?	Soft ☐	Gas Permeable ☐		
What is your replacement schedule?	Daily ☐	2 week ☐	Monthly ☐	

List any eye surgeries _____

List any eye diseases or conditions _____

List any eye injuries _____

Check any of the following that apply to YOU

☐ BLINDNESS	☐ HEADACHES	☐ HALOS AROUND LIGHTS
☐ EYE TURN	☐ BLURRY VISION	☐ LIGHT SENSITIVE
☐ LAZY EYE	☐ DOUBLE VISION	☐ FREQUENT STYES
☐ KERATOCONUS	☐ EYES HURT OR TIRED	☐ RED EYES
☐ MACULAR DEGENERATION	☐ FLOATERS	☐ EYES ITCH
☐ RETINAL DETACHEMENT	☐ FLASHING LIGHS	☐ EYES BURN
☐ GLAUCOMA	☐ SANDY EYES	☐ EYES TEAR
☐ CATARACTS		☐ EYES FEEL DRY

How many hours a day do you use a computer?

☐ > 1 hour ☐ 1-2 hours ☐ 3-5 hours ☐ 6-12 hours ☐ Over 12 hours

Do you have any visual symptoms due to computer use?

☐ TIRED EYES ☐ DRY EYES ☐ BLURRY VISION OTHER _____

Primary Care Physician's name: _____ Last Visit:_____

List **ALL** medications you are currently taking **(Including OCT and Vitamins):**

_____

_____

_____

List **ALL** medications you are **allergic** to:

_____

_____

_____

Are you pregnant or nursing?

☐ Yes ☐ No

Did you receive a flu vaccination this year?

☐ Yes ☐ No

Insurance requires BMI to be calculated for yearly exam. Please list **height and weight**.

Height _____ Weight_____

Check any that apply to YOU

☐ MIGRANES	☐ ARTHRITIS	☐ HIGH BLOOD PRESSURE
☐ MULTIPLE SCLEROSIS	☐ ALLERGIES/HAY FEVER	☐ STROKE
☐ DIABETES	☐ ASTHMA	☐ ANEMIA
☐ THYROID PROBLEMS	☐ EMPHYSEMA	☐ CANCER

Please describe any conditions that are present in your FAMILY.

Family History Is Unknown/ Adopted _____

	RELATIONSHIP TO PATIENT		RELATIONSHIP TO PATINET
Poor vision	_____	Cancer	_____
Blindness	_____	Diabetes	_____
Eye turn	_____	High Blood Pressure	_____
Lazy Eye	_____	Stroke	_____
Glaucoma	_____	Thyroid Disease	_____
Cataracts	_____	Other	_____
Macular Degeneration	_____	If yes explain	_____
Retinal Detachment	_____		

Social History

How often do you smoke or use tobacco products?

☐ Never ☐ Daily ☐ Occasional

How often do you consume alcohol?

☐ Never ☐ Daily ☐ Occasional

Do you have?

☐ Hepatitis ☐ HIV ☐ STD's

Occupation_____

Employer _____

DID ANYONE REFER YOU TO OUR OFFICE?

If yes tell us who

_____

_____

Patient Signature _____ Date_____