WELCOME TO ADVANCED EYECARE & VISION GALLERY

The Office of Dr. Tarbell & Associates

Please take a few moments to fill out **both sides** of this form. Thank you.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name ______________________ Nickname ____________ Date______________

Street ______________________ City ______________ State_______ Zip______________

Date of Birth____/____/_____ Age __________ Sex M F Social Security _____-_____-_____ Email ______________________

Home Phone______________ Cell Phone ______________ Work Phone ______________ Best time to call __________

Spouse (or Parents) Name ______________________ Spouse (or Parents) Work Cell Phone ______________

Your Employer or School ______________________ Occupation ______________________

Vision Insurance ______________ Health Ins ______________ FLEX SPENDING ACCOUNT Yes No

Name of Insured ______________ Date of birth____/____/_____ Relationship to Patient______________

Primary Care Physician ______________________ Physician's phone number ______________________

Who May We Thank for Referring You? ______________________ Purpose for today's visit ______________________

Your Family Medical History

*Please indicate relationship - **S** - Self **C** - Child **M** - Mom*
***D** - Dad **PG / MG** (Paternal or Maternal Grandparent) **N** - No one*

	S	C	M	D	PG	MG	N
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐
Eye surgery type/when __________?	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐
Strabismus / Eye Turn / Lazy Eye	☐	☐	☐	☐	☐	☐	☐
Vision therapy	☐	☐	☐	☐	☐	☐	☐
Light sensitivity	☐						
Tearing eyes	☐						
Dry eyes	☐						
Itchy eyes	☐						
Burning/Redness	☐						
Eye Injury ______________	☐						
Floaters	☐						
Flashing Lights	☐						
Headaches	☐						

Other ______________________

Allergies ______________________

Do you wear Contact Lens? Y N Satisfied with your current brand? Y N

How many hours per day do you wear your CL? ____ Days per week___

Name of <u>current medications</u> such as Antihistamines, Pain, Birth Control, Eye drops, Other ______________________

Lifestyle Questionnaire

YOUR last eye exam ___/___/___ By Dr.______________

Please describe your occupation______________

Does your job involve any of the following? (please include # hours)

Bookkeeping Y N # hours____ Blueprint reading Y N # hours______

Computer use Y N # hours______Steady or on and off? ______

Viewing fine details or technical manuals Y N # hours______

Equipment repair Y N # hours______

Please circle your hobbies and other visual demands:

Water sports or fishing Reading Computer Use

Arts, crafts, or sewing Cards/Board games

Musical Instruments: ______________

Outdoor activities: Hunting Yard work Golf

Gym activities: Aerobics Weight lifting Racquet Sports

Other Sports: ______________

What would you like to improve about your vision? Distance__ Near__

Other _______ Are you satisfied with your night vision? Y N

When are you bothered most by glare? (<u>please circle</u>): Night, day, driving, by water, off paper surfaces, on computer screens, overhead or fluorescent lights, reflections off your glasses, other: __________

Have you had or have you considered LASIK or Contact Lenses? Y N

Do you wear sunglasses? Y N

Do both your glasses & sunglasses have 100% UVA protection? Not sure Y N

What frame features are most important to you?

Style__ Durability__ Warranties__ Lightweight__ Hypoallergenic___

Did you know:

- Approximately 80%of brain activity is influenced by vision!
- Flexible Spending Accounts (FSA) monies can be used for all services and eyewear we provide.
- Frames from our office come with a **two year warranty** and a lifetime of adjustments and appreciation ☺ !

*The Doctors & Staff at Advanced Eyecare & Vision Gallery would like to **Thank You** for allowing us to provide you with excellence in eye health care. By optimizing your vision skills we enhance your quality of life.*

WELCOME TO ADVANCED EYECARE & VISION GALLERY

We provide the highest quality professional eye and vision care for our patients. In return for our uncompromising standards and service, we ask that our patients keep their accounts current. Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered, or eye wear is ordered. We do accept Visa and MasterCard to aid in your budgeting of expenses. After 30 days, balances are considered delinquent, and are subject to a billing charge ($15) each time we are required to send you a statment. We appreciate your notifying us at least 48 hours in advance if you should need to change your appointment with us. Appointments missed without a minimum of 24 hours advance notice are subject to a $95 missed appointment fee. ________
Initial

We are happy to help you with your insurance. Please be aware that if you are using insurance for today's visit, your insurance coverage is a contract between you and your insurance company – *Not Us.* Please enter your credit card #___________________________________ and expiration date _______. We will keep this information on file for your convenience. If your insurance company has not reimbursed our office within the allotted 60-day time period, we will utilize this information to process your balance. _________
Initial

If you have **vision coverage** for **routine** eye examinations or **medical coverage** for problem visits with a company with which we have an agreement (**Vision Service Plan, QualCare, Aetna, CIGNA**, **BCBS**) AND you bring us a current insurance card on the day of your visit, we will gladly accept contracted payments from your plan directly. Routine eye examinations result in prescriptions for eyeglasses; <u>contact lens examinations incur additional fees</u>, and are not usually covered by insurance. Corneal topography is a required procedure for all contact lens patients. The $65 charge will be itemized on your receipt. Likewise, medical conditions such as "lazy eye," diabetes or headaches, may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. Copayments and overages are due on the day services are received and materials ordered. If you notify us *after* services are received, we will supply you with a coded receipt you can submit to receive reimbursement directly from your plan. However, be aware that if we are not notified when services are rendered, your insurance company may only send you a partial reimbursement for services received. ________
Initial

When a health condition exists, the fees for medical testing can be submitted to your **Major Medical** insurance or Medicare. (Major Medical and Medicare will not usually cover *routine* examinations, nor measurements taken for eye wear unless you have vision coverage.) If your visit might be covered under major medical, we will give you a coded receipt you can mail to your insurance company for reimbursement. (For Medicare, we submit the forms for you.) The insurance company will reimburse *you* directly, not us, unless you are in a contracted plan listed above. **Please remember it is your responsibility to ensure all referral and certification procedures are followed.** These procedures may require a referral from your primary care physician, in which case *you must bring the referral form, and your current insurance card on the day services are received*, and pay any applicable copayments. We have tried, but unfortunately we cannot do this for you, as it comes from the office of your primary care physician. Without your insurance card and forms, you may receive only a partial reimbursement, or no coverage at all. ________
Initial

The **Health Insurance Portability & Accountability Act of 1996 ("HIPPA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPPA", we have prepared a **"Notice of Privacy Practices Policy"**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website. _________
Initial

Communication is the key to good relationships. Please feel free to ask any questions you have and we will be happy to help you.

The Staff and Doctors of Advanced Eyecare & Vision Gallery.

The Doctors or staff may discuss my situation or condition with the following individual(s).

Name____Relationship_________________________

Name____Relationship_________________________

Please sign below: With this signature on file, I also permit the office staff to submit my charges to my insurance company for reimbursement.

Signature:____Date:__________________