

# Patient History Information



Name: \_\_\_\_\_

## Personal Eye History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract             | <input type="checkbox"/> Yes <input type="checkbox"/> No Mucous                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Flashes of Light  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Color Blindness      | <input type="checkbox"/> Yes <input type="checkbox"/> No Redness                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Floaters or Spots |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma             | <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred Distance Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No Itching           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Macular Degeneration | <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred Near Vision     | <input type="checkbox"/> Yes <input type="checkbox"/> No Dryness           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Light Sensitivity    | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Pain or Soreness    | <input type="checkbox"/> Yes <input type="checkbox"/> No Burning           |

## Personal Health History

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ears, Nose, Throat, Mouth                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin (rash, itching, skin cancer, etc.)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular (heart, hypertension, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Neurological                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory (asthma, emphysema, etc.)      | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric (anxiety, depression, etc.)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine (diabetic, hypothyroid, etc.)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Genital, Kidney, Bladder                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood/Lymph (anemia, cholesterol, etc.)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Muscles, Bones, Joints (arthritis, etc.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergic/Immunological (seasonal allergies, Lupus) |

## Current Medications

(Provide a List)

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_

## Family Eye History

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blindness        | <input type="checkbox"/> Yes <input type="checkbox"/> No Macular Degeneration |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract         | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma         | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma Suspect | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease      |

## Social History

Do you drink alcohol?  Yes  No If yes, how much/often?  Occasional  1 per day  2-3 per day  4+ per day  
Do you smoke?  Yes  No If yes, how much/often?  Occasional  1/2 pack/day  1+ pack/day  
Method of Tobacco intake?  Smoking  Chewing  Vaping Former Smoker  Yes  No When did you quit? \_\_\_\_\_

## Primary Care Physician

\_\_\_\_\_

Primary Care Physician and Clinic Name

\_\_\_\_\_

Address of Primary Care Physician City State/Zip Phone

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Patient History Information

## Medical Records Access and Release Authorization Form

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Last 4 SSN: \_\_\_\_\_

Patient's Address \_\_\_\_\_ Patient's Phone Number: \_\_\_\_\_

I understand that by authorizing the following person(s) that:

- 1.) My medical record information may contain information of a sensitive or extremely private nature, including, but not limited to, medical history, abnormal test results, various prescriptions, financial records, and any other medical conditions for which I have been treated.
- 2.) This authorization may be revoked/modified at any time by writing to Yancey Eye Center except to the extent that information has already been disclosed. If information has already been disclosed in reliance on the authorization, revoking it will only prevent future disclosure.

Authorized Person's Name: \_\_\_\_\_ Authorized Person's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorized Person's Phone Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Assignment and Release

Insurance quotes received from our office are an estimate *only*. By signing below, you acknowledge that your policy is an agreement between you and your insurance company and *not* with our office. You also agree to release assignment to Yancey Eye Center for payment. Be assured that we will make every effort to collect from the insurance company. If after 90 days, your insurance company has not paid your claim, we retain the right to ask you to pay this claim and for you to contact your insurance company for reimbursement. All claims that are not paid within 90 days of your first billing cycle can be sent to a Collection Agency. The Collections Agency will add a collections fee (50% of account balances) that you agree you will pay in addition to the original account balances.

Our office contracts with several insurance companies; however, as you know, these contracts can change or we may drop out at anytime without notice. We will verify your medical and/or vision insurance plans via telephone or upon arrival to our office and will inform you if we are no longer participating with that insurance provider. Unfortunately, **WE DO NOT PARTICIPATE WITH THE FOLLOWING CARRIERS:** BCBS PathwayX, AmBetter, Spectera, Wellcare or Medicaid, and any HMO plan.

A returned check fee of **\$30.00** will be added to the cost of the returned checks. We ask that any NSF be made good within 10 business days. After 10 business days we have the right to take legal action.

Most eyeglass lenses are specifically manufactured to your specific prescription. Once the lenses have been ordered from the lab, a cancellation or refund cannot be offered.

You authorize Yancey Eye Center to release any and all information required to process insurance claims and to collect on your behalf.

You acknowledge that you have been given the opportunity to read the HIPPA agreement on file at Yancey Eye Center. Appointments with Yancey Eye Center will be scheduled as a common courtesy for patients and will be in consideration for your time. **Children under 18 years of age must be accompanied by a parent or guardian to be seen in our office or a parental authorization form must be signed and returned.** We require a 24-hour notice of cancellation as a courtesy to other patients seeking medical service. **A fee of \$65.00 will be charged for non-cancelled and missed appointments for all patients. A pattern of non-cancelled/missed appointments may result in discharge from the practice. If you are more than 15 minutes late for your appointment you will be rescheduled.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient History Information

## Medical VS. Routine Exams

Routine eye exams are for eyeglasses and contact prescriptions and must be filed to your vision plan. Any co-pays that apply to your vision plan will be due at the time of service and before eyeglasses and/or contacts can be ordered. If you are here for an eye exam and you have medical concerns or complaints such as Diabetes, Red Eye, Pain in the Eye, Burning, Flashes, etc., insurance requires your eye exam to be filled through your medical insurance plan. In this case you will be responsible for all co-pays, co-insurance, and deductibles at the time of service. If additional tests are performed such as visual fields, retinal scans, or photos these must also be filed to your medical insurance. You may address any concerns about your insurance and what your responsibilities are with our insurance coordinator prior to testing or being treated. By signing below, you agree to allow medical care to continue and that you acknowledge that you will be responsible for the patient share including any deductibles and copays.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Authorization for Alternative/Additional Testing

As part of a comprehensive (routine) eye exam, our office offers advanced technologies to create a photographic record of your retina. In most cases your vision plan will not cover the cost associated with these imaging options; therefore, your statement will reflect the charge of the test(s) you choose to have performed today.

How the tests benefit you:

- They provide your doctor the best possible information to diagnose, manage, and treat eye potential disease
- They are permanent, detailed records of your eye health and general health
- They can be transferred to other doctors and care providers almost instantly for further monitoring

The Clarus ultra-wide retinal imaging aids our office in the detection and diagnosis of ocular disease and allows us to track and monitor subtle changes over time with high resolution color images of your retina. The OCT wellness scan is a scan of your optic nerves and macula to obtain a baseline and is useful in detecting early glaucoma and macular degeneration. If you have any questions our staff will be happy to answer them. **Please note:** Retinal imaging is not a substitute for a dilated retinal exam, especially for those with Diabetes, Flashes and or Floaters.

If you wish to have this testing, please select one of the options below:

Clarus Ultra-Wide Retinal Imaging \$30

OCT Wellness Scan \$35

Wellness Package (Clarus & OCT) \$49

Patient Name: \_\_\_\_\_

Date : \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date : \_\_\_\_\_