TruVision EYE CARE

First Name: _____ Last Name: _____ Date: _____

Address: _____ Phone: _____

City/State _____ ZIP _____ Email: _____

Guardian (If Applicable): _____ Occupation/Hobbies: _____

Date of Birth: _____ Sex: M ☐ F: ☐ Last Eye Exam: _____ Last Medical Exam: _____

Primary Care Doctor: _____ Phone: _____Last 4 SS: _____

Medical History

Do you have any allergies to medication? _____

List any medications you take (prescription and/or over the counter): _____

_____

List of all major surgeries, eye injuries, and/or Hospitalizations: _____

_____

Are you pregnant and/or nursing? _____

Medical History	SELF	NO	**Family History Relatives (who)**	**Ocular History**	YES	NO
Arthritis	☐	☐	_____	Blurred Vision	☐	☐
Blindness	☐	☐	_____	Double Vision	☐	☐
Cataracts	☐	☐	_____	Dryness	☐	☐
Diabetes	☐	☐	_____	Excess Tearing/watering	☐	☐
Glaucoma	☐	☐	_____	Flashes of Light	☐	☐
Heart Disease	☐	☐	_____	Floaters	☐	☐
High Blood Pressure	☐	☐	_____	Itching	☐	☐
Kidney Disease	☐	☐	_____	Lazy Eye	☐	☐
Lazy Eye	☐	☐	_____	Pain/Eye Strain	☐	☐
Lupus	☐	☐	_____	Redness	☐	☐
Macular Degeneration	☐	☐	_____	Sensitivity to Light	☐	☐
Retinal Detachment/disease	☐	☐	_____	Others:_____		
Thyroid Disease	☐	☐	_____			
Other:_____	☐	☐	_____			

If you answer YES to any of the above or have a condition not listed above, please explain: _____

_____

_____

	YES	NO	
Do you wear glasses?	☐	☐	If yes, how old is your current pair of glasses? _____
Do you wear Contact lenses?	☐	☐	If yes, what kind of contact lenses? _____
Do you use tobacco/alcohol/illicit drugs?	☐	☐	If yes, type / amount / how long? _____

PLEASE COMPLETE THE BACK PAGE →

Pupil Dilation Information

In order to thoroughly assess the health of your eyes, the doctor needs to dilate (widen) your pupils using eye drops, the drops take about 20 minutes to take effect. Without dilation, the doctor is unable to completely see the inside of your eyes to look for any abnormalities such as diabetes, hypertension, heart disease, etc. Under some circumstances, dilation will be required in order to proceed with the exam. Side effects may include: blurry vision (especially at near) and sensitivity to light lasting up to 3-6 hours. We recommend that someone else drive if you have never had your eyes dilated or if you are uncomfortable driving after dilation.

I have read and understood the above information:

Signature_____Date:_____

I elect to defer dilation at this time due to the following reason(s):

__ Optos __ Recent Dilation __ Time Constraint __ Uncomfortable Driving ___Other:_____

Signature_____Date:_____

ANNUAL CONTACT LENS SERVICE FEE

Contact lenses are medical devices that require proper care and monitoring to ensure good vision and ocular health. **A Contact Lens Service or "Fitting" is the time and knowledge required to prescribe the most appropriate contact lenses for you and your eyes.** This service is *in addition* to your annual eye health exam and is typically not covered by vision plan exam benefits. The contact lens service fee varies by the complexity of your eyes, the type of contacts you require, and the amount of time necessary to achieve a proper fit. This fee is due at the time of your services and is nonrefundable. The service fee covers all "fit-related" follow-up visits for **3 months**. Office visits related to *medical conditions* that may develop will be billed to your *medical insurer*.

HIPAA PRIVACY: Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act **(HIPPA)** is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at TruVision Eye Care, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. **This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls. A detailed copy of Notice of Privacy Practices is attached on the last page and a copy will be provided to you upon request.**

FINANCIAL AGREEMENT

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company/Medicare and that final determination can only be made when the claim is process. It is my responsibility to provide my insurance information to TruVision Eye Care for billing purposes. I understand that billing any secondary insurance is my responsibility. I am financially responsible for the balance of my bill not covered under my insurance plan. A bank service fee of **$40** will be charge on any check returned for insufficient funds. Accounts 90 days old will be submitted to a collection agency.

I authorize the release of any medical or other information needed to process my insurance claim and request payment for all services today and any future service dates.

I have read and understand the Privacy Notice, the Financial Agreement, and the Contact Lens Service Fee policy of TruVision Eye Care. By signing below I understand and agree to these terms and my responsibilities as a patient.

_____

Patient / Guardian Name (Please print) Patient / Guardian Signature Date