PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Condition			
Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Condition			
AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

PATIENT GUIDELINES

-I understand that if during the course of my examination the doctor determines the need for medical testing & treatment, even though my insurance form states well vision, it will be filed to my medical insurance and I will pay all co-pays, etc.

-I understand that I am financially responsible for all fees, and agree to reimburse any and all fees for services and materials not collected in full should my medical insurance or vision benefit plan deny payment for services or materials rendered.

-I further understand that I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier by denial of medical services, unmet deductibles, non-covered services i.e., refractions, or uncollected fees for prior services.

-If I do not inform you that I have a vision plan or medical insurance before services are rendered, it will be assumed that no coverage exists and I am responsible for all payments.

-I agree this office, NO EXECPTIONS, will not file back claims or refund fees after services are rendered due to lack of notification of a vision benefit plan or medical insurance. It will be my responsibility to file my own claim and seek reimbursement from my insurance carrier.

-I have read and understand the notice of HIPAA and privacy policies and wish to continue care.

Office Policy

Contact lens fitting and evaluation is a Service and not a refundable fee

Due to the expense involved in contact lenses, the patient must pay at least a 50% deposit at the time of ordering.

If contacts are ordered through our office we will allow exchanges of previous prescription for the newest one as long as the contacts are unopened and not written on. They have to be in brand new condition. ***If a patient does not receive a contact lens fitting at the time of their exam, the patient can and must return to the clinic within 60 days to receive it at the discounted rate.**

Eyewear: McKinney Eyeworks has a no refund/no exchange policy; however, if the patient is dissatisfied with their vision and or their eyewear, it is the responsibility of the patient to return to the clinic within 30 days after receiving their eyewear to discuss the matter. If a patient returns to our office after 30 days, **an additional fee for a new refraction will be assessed.** McKinney Eyeworks is not responsible for the accuracy or the quality of eyeglasses filled from any outside optical.

There is a $20 charge for cancellation/no show without a 24 hour notice

Name____

Signature____ Date_________________

(Signature Required Covers Entire Document)

We take great pride in our patients.

Thank you for trusting McKinney Eyeworks with your eye care needs!