Antoine Eyecare Patient History

Personal Information

Mr. Mrs. Ms. Dr. Rev. Name: _____ Gender M F Date _____

Street Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell/Alt # _____ Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Name of Parent/Spouse _____

Hobbies / Sports _____ Email Address _____

HOW DID YOU HEAR ABOUT US? Walked by / Friend / Internet _____ / Insurance / Other _____

I have been provided with a copy of the HIPAA privacy policy to read. _____

Signature of Patient or Parent/Guardian **Date**

Insurance Information (Major Medical)

THIS INFORMATION MUST BE FILLED OUT COMPLETELY TO SUBMIT TO YOUR INSURANCE

Insurance Co _____ Member Id/ Subscriber # _____ Group # _____

Primary Insured's Name _____ Insured's DOB _____ Insured's Employer _____

Address of Primary Insured _____

Street City State Zip Code

Insurance Information (Vision or Secondary)

Insurance Co _____ Member Id/ Subscriber # _____ Group # _____

Primary Insured's Name _____ Insured's DOB _____ Insured's Employer _____

Address of Primary Insured _____

Street City State Zip Code

Medical and Ocular History

Do you wear Contact Lenses? **Y N** Brand? _____ Are you interested in contact lenses? **Y N** Do you wear glasses? **Y N**

When was your last eye exam? _____ Where was it? _____ Doctor? _____

Do you work at a computer terminal? **Y N** How many hours per day? _____ Are you interested in refractive surgery? **Y N**

Do you or any family member have a history of the following:

	NO	YES Self	YES Family
Eyes			
Blindness	☐	☐	☐
Blurred vision	☐	☐	☐
Burning/Itching	☐	☐	☐
Cataracts	☐	☐	☐
Chronic eye infections	☐	☐	☐
Crossed eyes	☐	☐	☐
Double Vision	☐	☐	☐
Dry eyes	☐	☐	☐
Excessive Tearing	☐	☐	☐
Eye Allergies	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Eye Surgery	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Glare/Light sensitivity	☐	☐	☐

	NO	YES Self	YES Family
Eyes Cont:			
Glaucoma	☐	☐	☐
Halos	☐	☐	☐
Loss of vision	☐	☐	☐
Macular Degeneration	☐	☐	☐
Mucous discharge	☐	☐	☐
Red eyes	☐	☐	☐
Retinal detachment	☐	☐	☐
Retinal Problems	☐	☐	☐
Other			
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Headaches	☐	☐	☐
Heart Diseases	☐	☐	☐
High Blood Pressure	☐	☐	☐

List any medications you are currently taking:

List your Past Ocular History and General Medical History (illness, surgery, injuries, treatments):

Comments on any Medical Condition:

Allergies Y N Explain:

Medical History

	NO	YES Self	YES Family
Musculoskeletal			
Arthritis	☐	☐	☐
Joint pain	☐	☐	☐
Neurological			
Seizures	☐	☐	☐
Other	☐	☐	☐
Genitourinary			
Kidneys	☐	☐	☐
Bladder	☐	☐	☐

	NO	YES Self	YES Family
Constitutional			
Fever	☐	☐	☐
Weight loss	☐	☐	☐
Weight gain	☐	☐	☐
Respiratory			
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Cardiovascular			
Heart Problems	☐	☐	☐
Vascular disease	☐	☐	☐

	NO	YES Self	YES Family
Hematologic/Lymphatic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Swelling	☐	☐	☐
Endocrine			
Thyroid problems	☐	☐	☐
Other glands	☐	☐	☐
Gastrointestinal			
Ulcers	☐	☐	☐
Other	☐	☐	☐

	NO	YES Self	YES Family
Ears, Nose, Mouth, Throat			
Sinus problems	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/Throat	☐	☐	☐
Chronic ear infections	☐	☐	☐
Allergic/Immunologic			
Hay Fever	☐	☐	☐
Medicine Allergies	☐	☐	☐
Systemic Allergies	☐	☐	☐
Psychiatric	☐	☐	☐

Comments on any Medical Condition:

Do you use tobacco products? **Y N** If yes, type, amount and how long? _____

Do you drink alcohol? **Y N** If yes, type, amount and how long? _____

Antoine Eyecare Patient History

Your insurance is meant to serve as a financial aid. We are happy to take assignment on your benefits. If you are not eligible for these benefits or are eligible for less than full coverage, your signature indicates that you agree to be financially responsible for the balance not paid by your plan.(Contact lens wearers-Rarely will insurance plans cover the entire exam, contact lenses, and professional fees for contact lens evaluations. Our office staff will make every effort to verify benefits for you). VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

WE HAVE A NEW APPOINTMENT SYSTEM!!!!!!!

PLEASE CHECK ONE OF THE BOXES ON HOW YOU WOULD LIKE TO BE CONTACTED FOR FUTURE APPOINTMENTS.

- ☐ TEXT MESSAGE
- ☐ PHONE CALL
- ☐ POSTCARD
- ☐ EMAIL

To Our Medicare Patients Only:

We are more than happy to bill Medicare for you. As a participating provider of Medicare, we will submit your claim. If the claim is approved, Medicare will reimburse our office 80% of the approved amount. **The remaining 20% (the co-payment) is your responsibility** as the Medicare beneficiary. You may also be responsible for a deductible and non-covered fees, as described below.

Deductible

Medicare has a yearly deductible of $100 that takes effect each January. If we are the first office to submit a claim to them, Medicare will notify us that you have not met your deductible and will not pay for your allowable fees. In which you are responsible for the amount not covered.

Exceptions, Non-Covered Services, Material Fees

Medicare only covers medical procedures, they will not cover a routine refractive exam. Meaning if there is only a diagonsis is made for a prescription (far or near sighted) and no separate medical diagnosis is made, Medicare will not cover fees for that visit.

Medicare does not cover glasses or contact lenses unless you have had cataract surgery.*
*Only pair is covered immediately following cataract surgery.

I have read and understand the information above and agree to pay for any services and materials I order, but which is not covered by Medicare. I also authorize Antoine Eye Care, LLC to bill any services that may be covered by Medicare.

Signature _____ Date _____