Welcome to Advanced Family Eyecare!

Tell us about YOU!

Last Name: _____ Gender: M/F

First Name: _____ Middle Initial: _____ Date of Birth: _____

Title: _____ Suffix: _____ Social Security #:_____

Nickname: _____ Marital Status: Single/Married/Divorced/Widowed

Address: _____ Employer Status: _____

City: _____ Employer: _____

State: _____ Zip Code: _____ Occupation: _____

Home Phone: _____ Preferred Language: _____

Daytime Phone: _____ Race: _____

Cell Phone: _____Text OK? _____ Ethnicity: _____

Email Address: _____

How would you like us to contact you (circle one)? Email Telephone Postal

How did you hear about us? _____

Patient Privacy

- **A copy of our privacy policies is posted in our waiting area and on our website madisoneyes.com. Free copies are available at our front desk. Per HIPAA guidelines, your consent is necessary for our office to discuss your eye care with others except for the exclusions listed in our policies. Please list below those you wish to allow us to discuss your care with.**

  - Name:_____ Relationship:_____
  - Name:_____ Relationship:_____
  - Name:_____ Relationship:_____

Office policies and procedures

- **Our office policies and procedures are available for review at our website *madisoneyes.com* or at our front desk. These policies include but are not limited to: contact lens fitting and refraction fees, eyeglass order policies, insurance filing, late fees for unpaid bills and emergency visit policies. If you have any questions at any time, feel free to ask one of our staff members.**

I acknowledge and accept the office and privacy policies of Advanced Family EyeCare.
I do ◯ I do not ◯ grant this office permission to bill my insurance company for any care I receive. I understand if medical eye conditions are being followed or treated, my medical insurance will be billed. If applicable, I grant permission for the minor under my care to be examined, diagnosed and treated if they are the patient here for care.

Signature_____ Date_____

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Patient Questionnaire

1. Medical Insurance Carrier _____ ID# _____

2. Secondary Medical Carrier _____ ID# _____

3. Preventative Vision care Carrier _____

4. Health history (Circle all that apply):
   a. Diabetes
   b. High Blood pressure
   c. High cholesterol
   d. Cancer
   e. Autoimmune disease (Lupus, Sjogren's, etc)

5. Current medications:
   a. _____
   b. _____
   c. _____
   d. _____

6. Medication allergies
   a. _____
   b. _____
   c. _____
   d. _____

7. Do you smoke? **Y/N** Drink Alcohol? **Y/N** Take Narcotics? **Y/N**

Signature_____ Date_____

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Medical insurance versus Preventative Vision Benefits:

Optometrists care for both "routine eye care" and medical eye care. If you have coverage for both, we will bill according to your complaint, diagnosis and previous orders from Dr. Tennant and any past eye doctors you may have seen.

Preventative vision benefits cover diagnosis and treatment of BLURRED VISION COMPLAINTS caused by nearsightedness, farsightedness, reading focus problems, etc. Such conditions can be treated fully and simply with glasses and/or contact lenses. Included in a preventative eye exam is an eye health assessment. Such an assessment is performed on a healthy eye to detect eye disease early in its progression. Whenever an eye disease is detected and needs to be treated or followed, preventative eye exams are no longer appropriate in the care of your eyes and your medical benefits will be used.

Medical benefits pay for eye exams when your complaint and diagnosis (present or past) involves a medical condition. A **partial** list of such conditions/complaints includes: diabetic eye exams, medically significant cataracts, pink eye, the monitoring of high-risk medication side effects on the eye (Tamoxifen and Plaquenil), glaucoma, the suspicion of glaucoma, sudden vision loss, flashes and floaters before your vision, foreign body in the eye, etc. **In these cases, your eye exam will be billed through your medical insurance.**

If you have any questions about this, please have a discussion with the staff or Dr. Tennant before your exam.

I have read and understand the preceding statement. I give permission for Dr. Tennant and the staff of Advanced Family EyeCare to bill out my exam consistent with this form.

Signature_____ Date_____

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REFRACTION NOTIFICATION

YOUR INSURANCE COMPANY REQUIRES YOU TO READ AND SIGN THIS FORM

To keep up with changes in health care and to allow our patients more choices in the use of their health care dollars, we have updated our policy on refraction in 2020.

A comprehensive eye exam involves two parts:

- **The Refraction: the test which determines the glasses prescription which best clears your vision. In addition to determining your final glasses prescription, refraction documents your best corrected vision in each eye (i.e., 20/20, 20/30, 20/100, etc.). We track your best corrected vision over time to determine whether eye diseases such as macular degeneration or cataracts are progressing. Best corrected vision also helps our office determine when it is time to refer you for such procedures as cataract removal.**
- **The Eye Health Assessment: the doctor evaluates your eyes for eye disease and manages any findings.**

Please be aware that if we are filing medical insurance for today's visit, medical insurance typically considers the refraction to be "routine vision" and this portion of the exam is non-covered (unless you specifically have routine vision coverage under your medical insurance). The refraction portion of the examination is an out of pocket expense in the amount of $33.00 and is payable by the patient at the time of service.

PLEASE CHECK ONE:

o **I want to have the refraction today**

o **I do not want the refraction today**

Signature_____ Date_____