



Today's Date: _____

Patient Information Questionnaire

Patient Name: _____ **Name Preferred:** _____
LAST FIRST MI

Mailing Address: _____
STREET CITY STATE ZIP

Home Phone#: _____ **Work Phone#:** _____

Cell Phone#: _____ **Email Address*:** _____

Date of Birth: _____ **Social Security #** _____

Marital Status (circle): Single Married Widowed Domestic Partner

Employer: _____ **(circle):** FT PT FTStudent PTStudent Retired

Occupation: _____ **Sex (circle):** M F

Emergency Contact: _____ **Phone#:** _____

How did you first hear about us?

(Circle) Sign Insurance Directory Flyer Postcard Radio Friend/Family, who? _____

Insurance – Policy Holder (if different from patient):

Full Name: _____

Employer: _____

Date of Birth: _____ Social Security # _____

[Check other side](#)

Patient Eye History

Reason for your visit today: _____

- | | |
|---|---|
| <input type="checkbox"/> Blurry at distance | <input type="checkbox"/> Blurry at near |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Flashes of Light |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Redness |

Previous Eye Doctor: _____

Date of Last Eye Exam: _____

Any special vision needs?

- Interested in trying Contact Lenses
- Interested in learning more about Lasik
- Need work related glasses – safety, computer, etc.
- Need recreational glasses – golf, fishing, etc.

Have YOU been diagnosed or have experienced:

- | | |
|---|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Lazy Eye/Amblyopia | <input type="checkbox"/> Eye Turn/Strabismus |
| <input type="checkbox"/> Color Deficiency | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Ocular Herpes |

Retinal Disease _____

Corneal Problems _____

Other _____

Eye Surgeries: _____ Date _____

*Email address may be used for communication with you _____

Eye Injuries: _____ Date _____

Current Eye Drop Prescriptions, over the counter eye drops or vitamins used: _____

Patient Medical History

Primary Care Physician _____

Phone Number _____

Have YOU ever been diagnosed with or had problems with any of these systems?

- | | |
|--|---|
| <input type="checkbox"/> Diabetes Type _____ When diagnosed? _____ | |
| <input type="checkbox"/> High Blood Pressure When diagnosed? _____ | |
| <input type="checkbox"/> Cancer What type? _____ | |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Endocrine (Glands) | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Muscle/Bone |
| <input type="checkbox"/> Blood/Lymphatic | <input type="checkbox"/> Immunological |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Depression/Psychiatric | <input type="checkbox"/> Cholesterol |

Other Issues Not Listed Above _____

Are You Currently...

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> A Smoker | |

Current Medications: _____

Major Surgeries _____

Allergy to Medications _____

Other Allergies _____

Family Medical/Eye History

along with occasional office news and promotions

Who? Which Side?

- | | |
|---|-------|
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Cancer (Type) _____ | _____ |
| <input type="checkbox"/> Blindness | _____ |
| <input type="checkbox"/> Cataracts | _____ |
| <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Corneal Problems | _____ |
| <input type="checkbox"/> Lazy/Turned Eye | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ |
| <input type="checkbox"/> Retinal Disease | _____ |

PRECISION EYE CENTER

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have reviewed the Notice of Privacy Practices for Precision Eye Center and have received a copy upon request.

Patient Signature (guardian if under 18)

Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
 2. Medical Insurance (such as BCBS and Medicare)
- Vision care plans ONLY cover routine vision exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases.
 - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
 - If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
 - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

Patient Signature (guardian if under 18)

Date

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Precision Eye Center, OD, PLLC, on my behalf, for any services and materials furnished. I authorize any holder, of medical, information about me to release to the Centers for Medicare and Medicaid Services and it's agents, any information, needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of CMS-1500 Claim form or electronically submitted claim) my signature authorized release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature (guardian if under 18)

Date

[Check other side](#)



CONSENT FOR PUPIL DILATION & RETINAL PHOTOGRAPHY

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to enlarge the pupils of the eye to allow the doctor to obtain a better view of the inside of your eyes. Temporary light sensitivity and loss of the ability to focus at near are common side effects of dilation and usually subside within 3 to 6 hours after instillation of the drops. Distance vision is usually not affected. However, if you have any concerns about driving immediately following this procedure, arrangements can be made to reschedule for a more convenient time. Risks without test: Possibility of not detecting eye disease that could lead to blindness (i.e. glaucoma, retinal tears or disease, etc.). There is no additional fee for dilation.

_____ I ACCEPT recommendation _____ I DECLINE recommendation

INITIAL: _____

Precision Eye Care is pleased to offer DIGITAL RETINAL PHOTOGRAPHY as an extension to our comprehensive eye health and vision examinations. This is a quick, painless procedure that uses advanced digital photography to document the important anatomical structures of the back of the eye WITHOUT the use of dilating drops. This instrument provides important diagnostic information for Dr. Ly and the results will be shared with you during your exam. They will become a permanent part of your electronic medical record in our office and form a baseline to track any subtle changes from year to year. **There is an additional fee of \$35 for retinal photography.** In certain cases, the photos may be medically necessary and will be filed to insurance.

WE HIGHLY RECOMMEND THIS PROCEDURE FOR ALL OF OUR PATIENTS

_____ I ACCEPT recommendation _____ I DECLINE recommendation

INITIAL: _____

Services and Glasses Policy (Effective 01/01/2021)

- **No refunds on professional services (eye exams, medical visits, and contact lens fittings).**
- Patient is responsible for fees not paid by insurance plan (deductibles, co-pays, or non-covered services). We try to obtain insurance benefits in advance to estimate coverage.
- **Glasses Return and Refund:** We will issue 50% refund of what the patient paid within 30 days of picking up glasses. Glasses are custom made and we have already incurred lab costs.
- **Frame Exchange:** Patient will pay the difference in the frame upgrade and a \$25 restocking fee. Limited to one exchange per original order. Must be done within 30 days of pickup.
- **Prescription Recheck:** A complimentary prescription recheck is allowed within 30 days of picking up glasses. \$40 refraction fee will apply after the 30 days.
- Glasses and contacts must be picked up within 30 days of notification.
- Medicaid and some insurance companies have their own labs, and we have no control over quality and timing.
- **We do not give out pupillary distances (PD). They are not part of the glasses prescription.**
- **Full payment must be received before orders are placed. No partial payments or deposits.**
- We only accept credit card and cash payment.

I have read and agree with these policies.

Patient Signature (guardian if under 18)

Date

Contact Lens Policy

- A contact lens fitting fee applies every year to issue or renew a contact lens prescription. This fee covers the service required to properly fit a patient for contact lenses, as well as trial lenses, and necessary follow-up visits within 90 days.
- There will be a \$35 training fee for first time contact lens wearers
- **Contact lens prescriptions are valid for one year, according to NC law. Contact lens prescriptions must be finalized within 90 days of fitting. Follow-ups after the 90 days will be subject to an additional fee.**
- Contact lens fitting fees are non-refundable, regardless of whether the patient decides to wear contact lenses or not. Our contact lens fitting fees range from \$70 - 600. Insurance coverage and copays may vary.
- Contact Lens fittings must be done within 90 days of exam, or you will need a new exam.
- Contact lens prescriptions will only be released after the fitting is successfully completed (exam, fitting, necessary follow-up visits) and after all fees are paid.
- There is no refund on custom ordered contacts, opened boxes, marked boxes, or color contacts because of dissatisfaction with the color.
- Full payment must be received before orders are placed. No partial payments or deposits.

I have read and agree with these policies.

Patient Signature (guardian if under 18)

Date

