Precision Eye Group
Medical/Eye History

Name _____ Birth Date _____

Medical Dr. _____ Pharmacy _____

Do YOU have any of the following (if so, please circle and explain)?
Genitourinary problems (bladder/Kidney) _____
Ear/Nose/Throat problems _____
Gastrointestinal problems _____
Musculoskeletal disorders _____
Heart Disease _____
Blood Disorders (anemia) _____
Allergies _____
Breathing problems (asthma/COPD) _____
Neurological disorders (MS/migraines) _____
Skin diseases (rosacea/eczema) _____
Psychiatric disorders (anxiety/depression) _____
Endocrine disorders (diabetes/thyroid) _____
Other _____

What, if any, medications are you allergic to?_____
Do you drive? _____YES _____NO Do you use tobacco? _____YES_____NO
Do you use recreational drugs?_____YES_____NO Do you use alcohol? _____YES_____NO
Have you ever had surgery? (if so, explain) _____
Have you ever been hospitalized? (if so, explain)_____
Have you ever had eye surgery? (if so, explain) _____
Are you pregnant?_____YES_____NO

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

Diabetes _____
High Blood Pressure _____
Heart Disease _____
Stroke _____
Lung Disease _____
Thyroid Disease_____
Cancer (what type?) _____

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

Cataracts _____
Glaucoma _____
Macular Degeneration _____
Lazy Eye _____
Dry Eye _____
Diabetic Retinopathy _____
Blepharitis _____

Please list all medications, including over-the-counter products, vitamins and nutritional supplements

_____

_____

_____

PRECISION EYE GROUP

PATIENT NAME _____ BIRTHDATE _____Title:
LAST FIRST M.I.

Mr. ☐
Mrs. ☐
Ms. ☐
Miss. ☐
Dr. ☐
Rev. ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL ADDRESS_____

PREFERRED CONTACT: HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ SEX: MALE ☐ FEMALE ☐

PLACE OF EMPLOYMENT _____ OCCUPATION _____

STATUS: FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ DISABLED ☐ STUDENT ☐ RETIRED ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

ETHNICITY: HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐

Race:
Native American ☐
Alaska Native ☐
Asian ☐
African American ☐
Pacific Islander ☐
White ☐

PREFERERRED LANGUAGE_____

SOCIAL SECURITY NUMBER_____

HOW DID YOU HEAR ABOUT US_____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE_____

PHONE _____ SOCIAL SECURITY NUMBER _____ DOB _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S NAME_____

INSURED'S EMPLOYER _____ INSURED'S BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE AND/OR MEDICARE PAYMENT IS 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 CARE ON MY BEHALF FOR ANY SERVICES AND MATERIALS FURNISHED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. IF I HAVE OTHER HEALTH INSURANCE COVERAGE (AS INDICATED ON ITEM 9 OF THE HCFA-1500 CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM), MY SIGNATURE AUTHORIZES RELEASE OF THE ABOVE MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN, AND AUTHORIZES MY DOCTOR TO ACT AS MY AGENT, AS ABOVE. FURTHER, IT IS THE PATIENT'S UNDERSTANDING THAT HE/SHE IS RESPONSIBLE FOR ALL FEES OF PRECISION EYE GROUP NOT COVERED BY MEDICAL INSURANCE AND IN THE EVENT THAT A STATEMENT FOR FEES IS NOT PAID WITHIN THIRTY (30) DAYS OF THE DATE DUE, THE PATIENT SHALL BE FURTHER OBLIGATED TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT THE RATE OF 18% PER ANNUM. REVISED MAY 2018.

SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN ☐ POA ☐ CAREGIVER ☐ PATIENT NOT MENTALLY/PHYSICALLY CAPABLE OF SIGNING ☐

PRECISION EYEGROUP

Authorization to Release Medical Records

Patient Name: _____

Address: _____

Birthdate: ____/_____/_____ Social Security #: _____

I authorize _____ to Release my Medical Records to:

☐ Precision Eye Group
3319 Lake Ariel Highway
Honesdale, PA 18431

or

☐_____
_____
_____

Information to be Released:

☐ Office Notes ☐ Photographs ☐ Diagnostics Tests ☐ Copies of correspondence ☐ Other

Purpose or Need for Disclosure:

☐ Further medical care ☐ Disability determination ☐ Vocational rehabilitation eval

☐ Payment of insurance claim ☐ Personal ☐ Application for insurance

☐ Legal investigation/response to subpoena ☐ other _____

I understand that I may revoke this authorization at any time and that this consent will automatically expire within 1 year of the date signed. This authorization hereby releases the sender from all legal responsibility or liability which may result from the release of my medical records. I understand that if the individual authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

_____ _____
Signature of Patient or Legal Guardian Date

If signed by legal representative, relationship to patient _____

PRECISION EYEGROUP

About Your Vision Care Plan & Your Medical Insurance

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and Precision Eye Group accepts most vision care plans and insurance plans in both categories: (1) vision plans and (2) medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision Plans cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Vision plans do NOT provide MEDICAL EYE HEALTH CARE NEEDS.
- Medical Insurance MUST be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.
- If you have both vision care benefits and medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.
- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your vision plan provider and medical insurance card(s) and identification, for your benefit, to our team member so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

☐ I have read and accept this office procedure.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name