SCHOFIELD VISION CENTER, Inc

David Hironaga, O.D., Peili Lin, O.D. and Associates

PATIENT INFORMATION

Date _____

Last Name_____

First Name_____ MI_____

Date of Birth_____Age _____

Sex - M or F

Address_____

City_____State____ Zip_____

Phone_____

Email Address_____

Emergency Contact_____

Phone_____Relationship_____

What is the major purpose of this visit?

☐ Eye Exam ☐ Contact Lens Exam ☐ Both

☐ Other: Please Explain_____

Please note Tricare and HMSA Federal Plan **DOES NOT** cover the cost of the contact lens fitting. You will be responsible to pay the cost out of pocket. Initial_____

INSURANCE INFORMATION

Name of vision care insurance?

☐ **Tricare Prime** ☐ **Tricare Select** ☐ **EYEMED** ☐ **None**

***EYEMED may have cost shares or co-pays.**

Do you have medical or vision insurance with any other insurance company?

☐ No ☐ Yes (Please List)_____

Have you used your vision insurance in the past 12 months?

☐ No ☐ Yes

I, undersigned, certify that I (or my dependent) have insurance with _____
I have assigned directly to Schofield Vision Center, Inc. all insurance benefits, if any otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** I hereby authorize Schofield Vision Center, Inc. to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions.

Signature_____ Date_____

SPONSOR INFORMATION

Name_____

Rank_____

SSN_____ Unit _____

☐ Active Duty ☐ Retired

** Title 18,US Code Part I, Chap 33, Sect 701 states it is unlawful to photocopy a military ID **UNLESS** it is being done to facilitate medical care, verify eligibility or file an insurance claim.

PATIENT EYE HISTORY

Date of last eye exam_____

Are you a current contact lenses wearer? ☐ No ☐ Yes

What kind? _____

Solutions used? _____

Are you satisfied with the vision and comfort of your current lenses? ☐ No ☐ Yes

ACKNOWLEDGEMENT OF RECEIPT of Notice of Privacy Practices

I acknowledge that I read a copy of Schofield Vision Center's Notice of Privacy Practices with effective date of September 23, 2013.

Initial_____ Date _____

I authorize Schofield Vision to send communications (to include prescriptions) to the following email address:

Email _____

PATIENT EYE HISTORY:

Please indicate if you are currently experiencing or have a history of the following eye conditions or symptoms: *(when not wearing correction*).

	No	Yes		No	Yes		No	Yes
Blurred Distant Vision	☐	☐	Dry Eyes	☐	☐	Chronic Headache/Migraine	☐	☐
Blurred Near Vision	☐	☐	Burning Eyes	☐	☐	Light Sensitivity	☐	☐
Eye Pain or soreness	☐	☐	Eye Injury	☐	☐	Poor Night Vision	☐	☐
Difficulty Reading for			Eye Surgery	☐	☐	Red Eyes	☐	☐
a Long Period of Time	☐	☐	Floaters or Spots	☐	☐	Watery Eyes	☐	☐
Crossed Eyes (lazy eye)	☐	☐	Glaucoma	☐	☐	Twitching Eyelid	☐	☐
Discharge from Eyes	☐	☐	Halos around lights	☐	☐	Temporary Loss of Vision	☐	☐
Double Vision	☐	☐	Itching Eyes	☐	☐	Other_____	☐	☐

PATIENT MEDICAL HISTORY: Please indicate if you have had any of the following medical conditions:

Who is your primary medical doctor?_____ Last medical exam_____

	No	Yes		No	Yes		No	Yes
Arthritis	☐	☐	Heart Problems	☐	☐	High Blood Pressure	☐	☐
Diabetes	☐	☐	Thyroid	☐	☐	Other: _____		

Do you take any medications? (Including eye medications or over-the-counter medication)
If YES, please list: _____

Do you have any drug or food or other allergies? ☐ No ☐ Yes If Yes, please list: _____

Are you pregnant? ☐ No ☐ Yes Are you nursing? ☐ No ☐ Yes If Yes, # months postpartum:_____

Please be advised while pregnant and/or postpartum your vision may change requiring an additional eye exam that would not be covered under Tricare, especially if you have already utilized your benefit for the year. Initial _____

REVIEW OF SYSTEMS: Do you currently have any of the following problems? <u>If YES, please explain.</u>

	No	Yes	
Chronic fever, unexpected weight loss/gain fatigue	☐	☐	_____
Ear/nose/throat problems (e.g. hearing loss, sinus)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heartbeat)	☐	☐	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g. depression, anxiety, trouble sleeping)	☐	☐	_____
Allergic/Immunologic problems (e.g. hay fever, lupus, Sjogren's)	☐	☐	_____
Blood/Lymph problems (e.g. cholesterol, anemia, enlarged lymph glands)	☐	☐	_____

FAMILY AND SOCIAL HISTORY: Please indicate if there is a family history of any of the following medical conditions:

(Please indicate relationship to patient: **M**=Mother, **F**=Father, **S**=Sibling, **MGP**=Maternal Grandparent, **PGP**=Paternal Grandparent)

Arthritis	☐ No ☐ Yes____		Cataracts	☐ No ☐ Yes_____		Heart Disease	☐ No ☐ Yes_____	
Blindness	☐ No ☐ Yes____		Diabetes	☐ No ☐ Yes_____		High Blood Pressure	☐ No ☐ Yes_____	
Cancer	☐ No ☐ Yes____		Glaucoma	☐ No ☐ Yes_____		Other: _____		

Do you smoke? ☐ No ☐ Yes If YES, how much? _____ Do you drink alcohol? ☐ No ☐ Yes If YES, how much? _____

Is there anything not mentioned on this form that you would like the Dr. to know? _____

Patient's Signature_____ _____

(Parent or Guardian if patient is under 18 years of age) **Date**

Reviewed By:_____ Date:_____

Initials_____Updated_____ Initials_____Updated_____ Initials_____Updated_____

Diagnosis Code(s) _____ _____ _____ _____

Procedure Code(s) ☐ 92004 ☐ 92014 ☐ 92015 ☐ 92310 ☐ _____