

HEIGHTS EYE CENTER

Life style Vision Questionnaire

Name: _____

Date: _____

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? _____ No _____ Yes
If Yes _____ All the time _____ Sometimes
_____ Only for distance _____ Only for reading _____ Only for computer
- How important is it for you to see to read or use computer without glasses?
Very important _____ Important _____ Somewhat important _____ Not important _____
- How many hours per day do you: read? _____ use computer? _____
- Do you drive at night? Socially _____ Occasionally _____ As profession _____

Check the following activities you do on a regular basis:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Read newspaper, books | <input type="checkbox"/> Read medicine bottles | <input type="checkbox"/> Needlepoint | <input type="checkbox"/> Wall Street Journal |
| <input type="checkbox"/> Drive daytime | <input type="checkbox"/> Drive nighttime | <input type="checkbox"/> Shop | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Hunt or Fish | <input type="checkbox"/> Paint / Artist | <input type="checkbox"/> Cook |
| <input type="checkbox"/> Musician | <input type="checkbox"/> Play Cards / Dominos | <input type="checkbox"/> Movie theatre | <input type="checkbox"/> Dine in Restaurant |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Spectator Sports | <input type="checkbox"/> Bicycling, Roller blades, etc | |

Underline the above activities that you would like to see without glasses if possible

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

PATIENT MEDICAL HISTORY RECORD

DATE (MM/DD/YY)	REFERRED BY	BIRTH DATE
PATIENT'S NAME		SEX AGE
ADDRESS		PHONE (H)
EMPLOYER	OCCUPATION	PHONE (W)
SOC SEC NO.		PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
Yes No If YES, please explain: _____
2. Have YOU ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
Yes No If YES, please explain: _____
3. Have you ever had any surgery?
Yes No If YES, please provide date and reason _____
4. Have you ever been hospitalized?
Yes No If YES, please provide date and reason _____
5. Do you take any medications?
Yes No If YES, please list: _____
Do you take any eye medications: _____
Yes No If YES, please list: _____
6. Do you have any drug or food allergies?
Yes No If YES, please list: _____

Review of Systems

	Yes	No	If YES, please explain:
Do you currently have any of the follow problems?			
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinal problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, muscular degeneration)?
Yes No If YES, please explain: _____

Do you smoke? If Yes, how much? Drink alcohol? If Yes, how much

If employed, does your job include heavy computer usage?

Comments _____

Signature _____

Date _____

HEIGHTS EYE CENTER

Payment Policies

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

Eye Examinations & Refractions

Payment for routine eye examinations and refractions are expected at time of service. In some cases when a medical problem is found, we may be able to bill your medical insurance or Medicare.

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is **NOT** a covered service by Medicare or most insurance regardless of the reason for the test being performed. **Our office fee for a refraction is \$30.00 and this fee is collected in addition to the patient's co-pay.**

ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

Patient Signature

Insurance Policy

We participate in Medicare and a variety of insurance plans and will direct bill your insurance for medical services under these plans for which we have an agreement. In this circumstance you are responsible for applicable deductibles, co-payments and refractions. We cannot be responsible for negotiating claims with insurance companies. Services not covered by your insurance company are your responsibility regardless of the status of the claim.

Prior Authorization

Most HMO plans require you to obtain authorization for your visit from your primary care physician. It is **your responsibility to obtain this authorization. This authorization is required by your insurance company before you visit our office, even when the visit is for an urgent problem.**

Optical Goods

Payment in full is expected at the time of delivery for all contact lenses, contact lens supplies and for glasses and optical accessories.

Forms of Payment

For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express, Debit.

I have read or have had read to me, and understand and accept the Heights Eye Center payment policies.

Patient

Date