Davis Eye Care

Today's Date_____

Welcome to our office. The information you complete here will allow us to give you better care:

Name: Last _____ **First** _____ **MI**_____ **Male** **Female**

DOB_____ /_____/_____ **Social Security Number**_____

Address: _____

City_____ **State**_____**Zip**_____

Phone: Home( ) _____ - _____ **Cell**( ) _____ - _____ **Email**_____

***Medical* Insurance** _____

Policy #_____**Group#**_____

Insured Name_____ **DOB**_____/_____/_____

Insured's Social Security Number_____ Relationship: Self Spouse Child Other

***Vision* Plan** _____

Language Preference_____ **Race** _____ **Ethnicity:** Hispanic___Latino____Other_____

Primary Care Physician: _____ **Phone Number** (_____) _____-_____

How did you hear about Davis Eye Care?_____

Please circle S or F. **S** = Self **F** = Family member **Mark all that apply.**

General		**Psychological**		**Gastrointestinal**		**Skin/Integument**	
Developmental Disabilities	**S/F**	ADD	**S/F**	Ulcer	**S/F**	Eczema	
Cancer _____	**S/F**	Bipolar	**S/F**	Celiac	**S/F**	Herpes Zoster/Shingles	
Fatigue		Depression	**S/F**	Crohns	**S/F**	Herpes Simplex/Cold Sores	
		Anxiety	**S/F**	Colitis	**S/F**	Rosacea	
Ear, Nose & Throat				Acid Reflux	**S/F**	Psoriasis	
Laryngitis		**Cardiovascular**					
Sinusitis		Congestive Heart Failure	**S/F**	**GYN/Urinary**		**Endocrine**	
Dry Mouth		Hypertension	**S/F**	Nursing	**YES/NO**	Thyroid	**S/F**
Hearing Loss	**S/F**	Heart Disease	**S/F**	Pregnant Trimester:	**1 2 3**	Diabetes: Type 1 Type 2	
		Vasculitis	**S/F**	STD	**YES/NO**		
Neurology				Prostate Disease	**S/F**	**Hematology/Lymph**	
Cerebral Palsey	**S/F**	**Respiratory**		Kidney	**S/F**	High Cholesterol	
Epilepsy	**S/F**	Asthma	**S/F**			Anemia	
Migraines	**S/F**	Sleep apnea	**S/F**	**Muscular/Skeletal**			
Tumors_____	**S/F**	Emphysema	**S/F**	Osteoporosis	**S/F**	**Allergy/Immunology**	
Multiple Sclerosis	**S/F**	Bronchitis	**S/F**	Arthritis/Osteoarthritis	**S/F**	Lupus	
Stroke/CVA	**S/F**	COPD	**S/F**	Muscular Dystrophy	**S/F**	Sjogren's Syndrome	
				Gout		Rheumatoid Arthritis	

*Name*_____ *DOB*_____

Please list your current medications.

Drug Name	*Dose*	*Taken how often?*	*Reason?*

Drug, Food, or Seasonal Allergies: Yes ____ No _____ If yes, please list

_____

OCULAR HISTORY: Please circle S or F. S = Self **F** = Family member **Mark all that apply.**

S/F Nystagmus **S/F** Retinal Hole/Detachment **S/F** Eye Turn/Strabismus

S/F Eye Injury **S/F** Glaucoma **S/F** Glaucoma Suspect **S/F** Lazy Eye/Amblyopia

S/F Dry Eye **S/F** Cataract **S/F** Eye Surgery Dates: _____

S/F Keratoconus **S/F** Macular Degeneration **S/F** Other: _____

FAMILY MEDICAL HISTORY: Mark all that apply to a close blood relative.

Cancer Who:_____ Hypertension/Heart Disease Who:_____

Thyroid Who:_____ Diabetes Who:_____

SOCIAL HISTORY:

Alcohol Use: **Y**es **N**o If yes, #_____ drinks per day/ week/ month

Tobacco Use: **Y**es: some days ___everyday___ **N**ever **F**ormer

Type: cigarette/ cigar/ pipe/ smokeless Amount: _____ per day/ week

If former tobacco user, how many years ago did you quit? _____

I understand that all co-pay's and fees are due at time of service. I understand that I am responsible for any unpaid balances by insurance or other. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the office regardless of insurance. Accounts 90 days old will be sent to collections and I will be responsible for any fees associated with collection. I understand that I will be billed as my primary insurance and that billing of any supplement plans is my responsibility. I acknowledge I have read and/or received HIPPA Notice of Privacy Policies.

Patient Signature/Responsible Party_____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 Blue Cross/Blue Shield and Medicare).

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. 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 will 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 (parent if child) Date

DAVIS EYE CARE

www.davisicare.com
(256) 233-2393

Let us show you the difference at Davis Eye Care!

	Davis Eye Care	*Online Vendor*
Free Shipping on Annual Supply	✓	✓
Instant Savings on your annual supply purchase*	✓	
Exclusive Manufacturer Rebates*	✓	
Prescription Change Protection – if your prescription changes, we'll exchange your boxes**	✓	
Ability to process 100% of vision insurance benefits	✓	
30% discount on prescription glasses with same day purchase 25% discount on prescription sunglasses, or non-prescription sunglasses with annual supply order ***	✓	
Free nose pad replacements, cleanings, and adjustments on glasses	✓	
Free lens replacement of a torn or defected lens and free trial lenses if you run short close to your next appointment	✓	

***Some brand and insurance exclusions may apply**
****Offer applies to unopened boxes only purchased through us**
*****Lens and frame purchase required. Not valid on clearance, or with insurance, or any other discounts. Discount on prescription and non-prescription sunglasses valid 60 days from purchase of annual supply order.**