ARLINGTON EYE PHYSICIANS

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Patient's Home Address: _____

City, State, Zip: _____

Guardian Full Name: _____ Guardian Date of Birth: _____

Patient's Status: ◯ Male ◯ Female ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Please be advised this will be an automated message left on your voicemail or by anyone who answers this phone number.

Preferred Method: ☐ Home ☐ Cell ☐ Email

Patient's Home Phone: (_____) _____ Patient's Cell Phone: (_____) _____

E-Mail Address: _____

May we leave medical information on your voice mail at home? ☐ Yes ☐ No On your cell phone: ◯ Yes ◯ No

May we leave medical information with another person? ☐ Yes ☐ No If yes, with whom? _____

May we release medical information to your spouse? ☐ Yes ☐ No

Referring Physician Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____

Primary Care Physician Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

For a copy of our Privacy Notice please visit our website @ www.arleye.com

Patient's Signature: _____ Date: _____

HEALTH REFORM QUESTIONS:

RACE:

◯ American Indian or Alaskan Native
◯ Asian
◯ Native Hawaiian
◯ Black or African American
◯ White ☐
◯ Hispanic ☐
◯ Other Race _____
◯ Unreported/Refused to Report

ETHNICITY:

◯ Hispanic
◯ Non-Hispanic
◯ Unreported/Refused to Report
___ Primary Language _____

Please tell us in your own words what brings you to our office today: _____

Do you currently have any problems in the following areas?

EYES	YES	NO		YES	NO		YES	NO
Loss of vision	☐	☐	Loss of side vision	☐	☐	Recurrent infections	☐	☐
Poor night vision	☐	☐	Double vision	☐	☐	Eye pain or soreness	☐	☐
Redness	☐	☐	Dryness, sandy or gritty feeling	☐	☐	Glare/light sensitivity	☐	☐
Surgery to eye muscles	☐	☐	Sjogren's Syndrome	☐	☐	Foreign body sensation	☐	☐
Blurred vision	☐	☐	Night vision	☐	☐	Floaters or spots	☐	☐
Difficulty reading	☐	☐	Difficulty driving	☐	☐	Itching, burning	☐	☐
Difficulty seeing television	☐	☐	Mucous discharge	☐	☐	Flashing lights	☐	☐
Halos	☐	☐	Previously diagnosed cataracts	☐	☐	Tired eyes	☐	☐
Excess tearing/watering	☐	☐	History of retinal detachment	☐	☐			

Do you wear glasses? _____ How long have you had your current pair? _____

Do you wear contacts? _____ What type? _____ How old is the current pair? _____

Do you use tobacco? _____ If "YES", how much daily? _____

PLEASE CONTINUE ON OTHER SIDE

Are you allergic to any medications? If "YES", please list all.

_____

_____

MEDICAL HISTORY If you have now or in the past problems in any of these, please check box.

☐ Fever, weight loss	☐ Respiratory	☐ Neurological
☐ Ears, Nose, Mouth and Throat	☐ Gastrointestinal	☐ Psychiatric
☐ High Blood Pressure	☐ Genitourinary	☐ Endocrine
☐ Heart Disease	☐ Muscles/Bones	☐ Hematologic/Lymphatic (Blood)
☐ Heart Surgery	☐ Skin	☐ Allergic/Immunologic

FAMILY HISTORY

☐ Mom ☐ Dad ☐ Grandparent ☐ Sister ☐ Brother

☐ Cataract ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes ☐ Retina

The government has ruled that the part of your eye examination which determines your need for glasses must be charged separately from the **MEDICAL** portion of the exam. This is called a REFRACTION. Most insurance carriers will not pay this amount (currently $40.00). The patient is responsible for this charge and should pay at the time of service. We appreciate your cooperation with this new ruling.

PLEASE NOTE: If unable to keep your appointments, kindly give 24 hour notice, otherwise we reserve the right to charge for time reserved.

Patient Initial _____

In order for us to service your account or collect any amounts you may owe, you expressly authorize and specifically consent to allow us and our outside collections agencies, outside counsel, or other agents to contact you by telephone at any telephone number associated with your account that you have provided or may provide in the future, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us or may provide to us in the future. Methods of contact may include pre-recorded/artificial voice messages and/or use on an automatic dialing device, as applicable.

Patient's Signature: _____ Date: _____

I hereby authorize Arlington Eye Physicians, LLC to release to my insurance company, third party payer or their medical review companies, all medical information necessary to secure payment of medical services. I authorize Arlington Eye Physicians, LLC to contact my employer, if necessary, for insurance purposes. Redisclosure of this information by its recipients is prohibited except when implicit in the purposes of this disclosure.

I hereby authorize payment of all medical/surgical insurance benefits, including Medicare B, to which I/patient am or may be entitled, to be paid directly to Arlington Eye Physicians, LLC. I understand that I and the patient will be fully responsible for payment of any and all charges not covered by medical insurance.

If my insurance company requires a referral from my primary care physician, I understand that it is my responsibility to obtain that referral. If I do not obtain the referral, I understand that I am choosing to go outside of the managed care network and that I will be responsible for payment of charges in full.

Accounts unpaid after 90 days will be sent to an outside collection agency. You agree to reimburse us the fees of our collection agency, which may be based on a percentage at a maximum of 30% of the debt, all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

A $50.00 fee will be charged to your account for any appointments cancelled less than 24 hours from your scheduled appointment.

Full payment is required to place an order for glasses or contact lenses. All optical purchases are neither returnable nor refundable.

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Patient's Signature: _____ Date: _____

☐ Check here if signature is that of parent or legal guardian. Indicate relationship to patient: _____

If so, who is responsible for this bill: _____