Soundview Eye Center

WELCOME TO OUR OFFICE

Patient Name:
Mr. Mrs. Ms. _____ **SS#** _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ **Gender** _____ Home Phone _____ **Marital Status** _____

Cell Phone _____ Bus. Phone _____ **E-Mail** _____

Occupation _____ Employer _____

Primary Insurance Co. _____ ID # _____

Secondary Insurance Co. _____ ID # _____

Name of Insured _____ Relationship _____ SS# _____

Insured Employer _____ Insured Date of Birth _____

Name & Address of Financially Responsible Person _____

Primary Care Physician _____ Phone # _____

Whom may we thank for referring you to us? _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

GENERAL HEALTH				EYE HISTORY				CURRENT VISUAL PROBLEMS			
Do you have:	Y	N	In Family	Do you have:	Y	N	In Family	Do you have:	Y	N	In Family
Diabetes				Glaucoma				Blur at Distance			
Hypertension				Cataract				Blur at Near			
Heart problems				Eye Injury				Seeing Double			
Kidney problems				Lazy Eye				Seeing Flashing Lights			
Thyroid problems				Eye Surgery				Eyes Burn, Itch, Tear			
Arthritis				Macular Degeneration				Headaches			

Do you presently wear glasses? ❒ Yes ❒ No For how long? _____ For: ❒ Distance ❒ Near ❒ Both
Do you presently wear contact lenses? ❒ Yes ❒ No For how long? _____ ❒ Hard ❒ Soft
Are you interested in Contact Lenses ❒ Yes ❒ No Laser Refractive Surgery ❒ Yes ❒ No
Vision Therapy ❒ Yes ❒ No ❒ Both

Last Eye Exam: _____ Last General Physical Exam: _____

Are you currently taking any medications? (Please include regularly used over the counter medications)
You may continue the medication information on the back if additional room is required.

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

INFORMATION ON MEDICAL INSURANCE PLANS

Medical insurance will only pay for medically related eye examinations which require a medical diagnosis. If the main reason for your visit is for routine/yearly eye exam or contact lens check-up, your insurance plan may not pay and the patient is responsible for this fee.

Most insurance plans DO NOT pay for refractions (the part of the exam that checks for eyeglass prescriptions). The patient is responsible for this part of the fee.

Most medical insurance carriers and union plans do not pay for a contact lens evaluation or a contact lens fitting. The patient is responsible for this part of the fee.

Please initial _____

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE: We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Full payment for our services is due at the time services are rendered unless you are a member of an insurance plan in which we participate. We participate in many insurance plans and we accept assignment for those. "Accept assignment" still requires you to pay the required co-payment, co-insurance and deductibles applicable to your particular insurance plan. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, for example, routine eye care, refraction and contact lens evaluation.

Medicare and other insurances do not pay for the refraction part of the exam. If a refraction (the part of the exam that determines your need for a correction) is necessary, Medicare and some insurance carriers may disallow it, stating that it is not a covered benefit. Therefore, the patient will be responsible for the refraction charge, as well as for any other "non-covered" services. All co-pays must be paid at the time of the service. You will be responsible for all charges not covered by insurance benefits. If you belong to a managed care insurance plan and do not have a valid referral from you PCP, you are required to pay in full for the services rendered at the time of service. We accept cash, check and all credit cards. We request that you provide us with complete insurance information at the time of your initial visit. It is your responsibility to make us aware of any changes in your insurance.

MEDICAL RELEASE/LIFETIME SIGNATURE ON FILE/PAYMENT AUTHORIZATION

I authorize payment of all Medicare or other insurance benefits for services rendered for this office be make payable to Dr. Kraushaar. I authorize this office to release to the Centers for Medicare and Medicaid Services and its agents and/or any other insurance information necessary to determine the benefits payable for related service. I permit a copy of the authorization to be used in place of the original. The doctor listed above may, while acting in a professional capacity, disclose any and all information concerning my eye examination and visual status.
I hereby give my consent for my child or me to be examined and I understand my eyes or my child's eyes may be dilated during the examination.

SIGNATURE _____ Relationship _____ Date _____