Patient Information

Name_____ Occupation_____ DOB_____/_____/_____
Medical Doctor_____ Last Physical Exam _____/_____/_____ Last Eye Exam _____/_____/_____
Hobbies_____
Medications_____
Allergies_____

Ocular History	Family	Self
Cataracts		
Glaucoma		
Macular Degeneration		
Eye Allergies		
Styes or Chalazion		
Crossed Eyes or Amblyopia		
Other, please explain		

Major medical/surgical history:_____
_____
_____
_____
_____
_____
_____
_____

Allergic	Family	Self
Seasonal Allergies	☐	☐
Other	☐	☐
Cardiovascular		
Blood Pressure	☐	☐
Cholesterol	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Constitutional		
Fatigue		☐
Nausea, Fever		☐
Weight gain		☐
Weight loss		☐
Endocrine		
Hypoglycemia	☐	☐
Gout	☐	☐
Thyroid Disorder	☐	☐
Diabetes I (insulin)	☐	☐
Diabetes II (non-insulin)	☐	☐
Gastrointestinal		
Constipation		☐
Diverticulitis	☐	☐
Gall Bladder Disease	☐	☐
Gastric Reflux (GERD)	☐	☐
Hepatitis	☐	☐
Pancreatitis	☐	☐
Stomach Cancer	☐	☐
Ulcers	☐	☐

Genitourinary	Family	Self
Pregnant		☐
Menopause		☐
Bladder Infections	☐	☐
Dialysis	☐	☐
Renal Cancer	☐	☐
Ears, Nose, Throat		
Sinusitis	☐	☐
Deafness	☐	☐
Vertigo	☐	☐
Hematologic, Lymphatic		
Sickle Cell Disease	☐	☐
Leukemia	☐	☐
Lyme Disease	☐	☐
Lymphoma	☐	☐
Immunologic		
AIDS/HIV	☐	☐
STD	☐	☐
Lupus	☐	☐
Cancer	☐	☐
Integument		
Eczema	☐	☐
Skin Cancer/Rash	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cerebral Palsy	☐	☐
Multiple Sclerosis	☐	☐
Muscular Dystrophy	☐	☐

Neurological	Family	Self
Nerve Palsy	☐	☐
Epilepsy	☐	☐
Seizures	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Psychiatric		
ADD/ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Sensory Processing	☐	☐
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Social		
Tobacco	☐	☐
E-Cigarette	☐	☐
Alcohol	☐	☐

VFE:
WNL

Stereo:
WNL

Polycarb
1.67
1.74
Aspheric

SV
Bifocal
Trifocal
PAL
S Series

PD: _____
____ ____

Color:
WNL

A/R
Transitions
Polarized

Follow-up:
_____

Order:
Trials or Supply

Signature_____ Date_____/_____/_____

N E - G C - RP

Patient Information

Responsible Party (skip if same as patient information)
Name_____
Address_____
City _____ State _____ Zip_____
Home#_____ DOB_____
Work#_____ Male or Female
Cell#_____
SSN#_____

Patient Information
Name_____
Address_____
City _____ State _____ Zip_____
Home#_____ DOB_____
Work#_____ Male or Female
Cell#_____ Married or Single
SSN#_____
Employer_____
Occupation_____
Email_____
Race (check one):
Cauc.____ A. Am.____ N. Am.____ Other:_____
Ethnicity: Hispanic____ Non-Hispanic____
Primary Language: English___ Spanish____
Other____

At Within Sight P.L.L.C. we utilize an automated system to confirm and request appointments, receive appointment reminders, and be notified when eyewear is available for pick up. This system can also be used to submit surveys, reviews, and refer friends.

May we send you text reminders? Yes No
May we send you email reminders? Yes No
May we use your name/picture for marketing? Yes No

Medical Insurance
MEDICAL INSURANCE_____
Who holds the insurance_____
Relationship to patient_____ DOB_____
Policy#_____
Group#_____
SSN#_____

Vision Insurance
VISION INSURANCE_____
Who holds the insurance_____
Relationship to patient_____ DOB_____
Policy#_____
Group#_____
SSN#_____

What brings you to the office today? *Annual Vision Exam* *Contact lens Exam* *Medical Exam*

_____ I acknowledge that I have received a copy of Within Sight P.L.L.C. Notice of Privacy Policies. I also acknowledge this information is always available on their website ***withinsightvision.com***.

_____Digital retinal photography provides both the patient and the doctor with a digital photo of the back of the patient's eye and reduces the need for dilation if the pupils are large enough for clear, readable photos. This process can aid in the early detection of several disorders and eye diseases, such as brain tumors, glaucoma, diabetes, macular degeneration, and retinal lesions. **Insurance does not cover this**
There is an additional $39.00 charge for the Digital Retinal Photography Testing

Would you like a retinal photo taken today? Yes No

Person(s) authorized to receive information or materials from this office which pertain to me, my health status, my account at this office, or pending health or financial responsibilities related to this office. (**We are required to have you complete this by HIPAA/Privacy laws.**)

Name	Email	Phone	Relationship

Signature_____ Date_____

Within Sight Vision

Patient Financial Responsibility

This agreement will renew each year after the initial visit until the patient or patient's guardian states otherwise.

Eye Care Services: Our office provides a full scope of eye care services, including routine vision care (i.e. check-ups, glasses and contact lenses), as well as medical eye care services (i.e. eye infections, dry eye and lid disease, treatment and evaluation of ocular allergies, cataracts, glaucoma, and trauma related care). Payment for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer have purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier. Depending on the nature of your visit, we may be able to bill your vision plan insurance, your medical insurance , or both. Your medical insurance may be able to be billed for certain eye conditions and procedures that your insurance company deems medically necessary and has included in your policy. **Please present all of your insurance information to the receptionist upon arrival.** Even with this information, it is impossible for our office to determine with any certainty what, if any, charges will be covered by your insurance company. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless or insurance. In the event of a dispute or rejection of a claim, you are responsible for payment. If we do not contract with any of your insurance providers, you should assume your insurance is NOT accepted by this office and that payment for services will be due on the day of your visit. If you are an **HMO** insured patient, you may elect to see us and pay for the services directly or see your **HMO** primary care physician for a referral letter prior to visiting our office.

Materials: The payment for any balance is due when products are ordered. If after 90 days the order has not been picked up, you will receive a message that the order will be cancelled and the payment forfeited.

Records Release: We will provide a report of your most recent exam results and current spectacle and contact lens prescriptions upon request at no charge. If you request copies of your full medical records, there will be a charge of $0.25 per page and we will impose a minimum handling fee (including copies) of $10 plus the cost of delivery method that you choose (or the fee allowed by the State of Oklahoma at the time of the request). **All charges must be paid before the records will be released.**

Methods of Payment: All major credit cards, bank debit cards, checks, and cash will be accepted. There will be a $25 fee plus our bank fee for a returned check. Balances due, notwithstanding insurance balances, that are not paid in full within 30 days may be turned over to an outside collection agency for final payment. We will bill **one** insurance claim for you as a courtesy. For patients with more than one insurance company, additional claims can be billed on your behalf for a $10 processing fee.

I have read and understood the office financial policies and agree to the conditions above and further agree that I, as the patient receiving the services or the responsible party for the patient, am ultimately responsible for payment of any materials ordered and/or services rendered.

Acknowledgments, Assignment of Benefits Authorization, and Release of Medical Information

I have read, understood, and agree to the policies outlined above. I consent to the performing of optometric procedures agreed to be necessary or advisable. I authorize the release of any information contained in my records for the purpose of my treatment, billing and processing of insurance claims. I authorize all payments from my insurance carrier to made directly to Within Sight, P.L.L.C., DBA Chase V. Hunter, O.D. I certify that the information I reported with regard to my insurance coverage is correct. I will permit a copy of this for to be used in place of the original; the duration of this document is indefinite and continues until revoked in writing. I acknowledge that a copy of Within Sight, P.L.L.C., Notice of Privacy Practices has been made available to me to view and is always available to view at http://withinsightvision.com/privacynotice.html.

_____ _____ _____

Name Signature Date