ENVISION 20/20 ASSOCIATION

Welcome to our office!

For office use only:
New GEE CL-Sph / Toric / Mono/MF / RGP
Est. OV: _____ Other: _____
Temp : _____

PATIENT INFORMATION				
Patient Name (Last, First, MI)		Birthdate	Age	Date
Street Address		City	State	Zip
Home/Cell Phone	Work Phone	Email		
Employer	Occupation	Parent/Legal Guardian Name and Birthdate (if applicable)		

INSURANCE INFORMATION

We are happy to file your insurance claims or take assignment of your vision and/or medical benefits as designated by your insurance company. We will do all that we can to help you receive the maximum benefits. Please note that in the event there is a medical condition that needs to be addressed, we will be able to bill the medical insurance for the medical eye exam. The vision insurance will be billed for all your vision needs. Please bring a copy of your insurance card(s) and ID to the front desk.

Vision Insurance	Primary Member's Name	Primary Member's Birthdate
Primary Member's ID	Relationship to Primary Member ▢ Self ▢ Spouse ▢ Dependent	Last Four of Primary's SSN
Medical Insurance	Primary Member's Name	Primary Member's Birthdate
Primary Member's ID	Relationship to Primary Member ▢ Self ▢ Spouse ▢ Dependent	Last Four of Primary's SSN

REASON FOR TODAY'S VISIT

What is your eye problem/complaint today? *Please describe this problem as best as you can.*

Date of last eye exam: _____ Patient's Eye Doctor: _____

Do you wear glasses? ▢ Y ▢ N How old are the glasses? _____ Type (circle) : Bifocal Progressive Distance Near

Date of last medical exam: _____ Patient's Medical Doctor: _____

CONTACT LENS HISTORY

When was the last time you wore contacts? _____ ▢ First time contact lens wear

What type of contacts do you wear? ▢ Soft ▢ Hard ▢ Color ▢ Toric/astigmatism ▢ Bifocal/monovision

Contact lens brand: _____

How often do you replace your lenses? ▢ Daily ▢ 2 wks ▢ Monthly ▢ Other _____

How many times a week do you wear your lenses? _____

How often do you sleep in your lenses? _____

SOCIAL HISTORY

Smoke ▢ Yes ▢ No
If so, how often? _____

Alcohol ▢ Yes ▢ No
If so, how often? _____

Recreational drug use ▢ Yes ▢ No

REVIEW OF HEALTH

Do you or a family member have problems with any of the following (check all that apply)? Y=Yes N=No F=Family

Amblyopia (lazy eye)	▢Y ▢N ▢F	Constitution (fever, weight gain/loss, etc)	▢Y ▢N ▢F
Strabismus (eye turn)	▢Y ▢N ▢F	Cardiovascular (high blood pressure, high cholesterol, heart disease, arrhythmia, etc)	▢Y ▢N ▢F
Glaucoma	▢Y ▢N ▢F	Endocrine (diabetes, high/low thyroid, cancer, etc)	▢Y ▢N ▢F
Cataracts	▢Y ▢N ▢F	Neurological (stroke, headaches/migraines, paralysis, seizures, etc)	▢Y ▢N ▢F
Macular Degeneration	▢Y ▢N ▢F	Ear, nose, mouth/throat (hearing loss, sinus, sore throat, cancer, etc)	▢Y ▢N ▢F
Retinal Detachment	▢Y ▢N ▢F	Gastrointestinal (diarrhea, constipation, etc)	▢Y ▢N ▢F
Blindness	▢Y ▢N ▢F	Genitourinary (genitals, kidney, bladder, etc)	▢Y ▢N ▢F
Retinal Disease	▢Y ▢N ▢F	Musculoskeletal (arthritis, joint/muscle pain, etc)	▢Y ▢N ▢F
Other Conditions Specify:_____	▢Y ▢N ▢F	Integumentary (eczema, skin cancer, etc)	▢Y ▢N ▢F
Are you currently pregnant or nursing?	▢Y ▢N	Psychiatric (depression, anxiety, etc)	▢Y ▢N ▢F
		Hematologic/Lymphatic (anemia, bleeding problems, etc)	▢Y ▢N ▢F
		Allergic/Immunologic (lupus, allergies, etc)	▢Y ▢N ▢F

Please list all dates and type of surgery, including eye surgery:

Please list all current medications, including eye drops and non prescription meds:

Please list all allergies to medications, foods, and/or seasonal allergies:

Have you tested positive for COVID-19? If so, when? _____

In the last 14 days, have you or anyone in your household cared for an individual who is in quarantine or is presumptive positive or tested positive for COVID-19? ▢Yes ▢No ▢Family _____

Do you currently have any symptoms of COVID-19? ▢Yes ▢No

NOTICE OF PRIVACY POLICIES

- This office's privacy practice is in accordance with HIPAA regulations. You may obtain a copy of the notice at any visit. I acknowledge that a copy of the Notice of Privacy Practices has been made available to me.

_____

Signature (Patient or Guardian) Date

OFFICE POLICIES

- You may request that we provide copies of your exam and/or additional copies of your prescriptions. Please see the receptionist about our fee structure for those copies.

- CONTACT LENS EXAM:
    1. The fee includes the exam, fitting, and follow-up visits and is not refundable.
    2. The fitting fees vary depending on the complexity of the fitting dictated by the needs of your eyes. The fitting may or may not be covered by your insurance.
    3. Follow-up visits may be necessary for safeguarding your eyes' health and may be a required part of the exam process to determine the final prescription.
    4. A written contact lens prescription is not considered final until the follow-up visits are completed.
    5. **FOLLOW UP VISITS ARE TO BE COMPLETED WITHIN 30 DAYS.** Any follow-up visits after 30 days from the date of contact lens exam will be charged a reassessment fee.
       All visits after 6 months will be charged the entire contact lens exam fee.

- Prescription re-checks within 45 days of the exam date will be at no charge**.** Re-checks after 45 days from the date of exam will be charged a fee. After 6 months, a new general exam will be required.

_____

Signature (Patient or Guardian) Date

FINANCIAL RESPONSIBILITY

- In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. We go to great lengths to verify the insurance coverage you have. However, the final determination of your benefits will not occur until the insurance company receives your claim. In the event we determine that you are not eligible at the time of service, the undersigned will be responsible for any fees for all services and/or materials provided, including reasonable collection fees, regardless of insurance.

- I understand that I am responsible for any fees for all services and/or materials provided. I understand that payment from my insurance is to be paid directly to Envision 20/20 Association/Dr. Rosa Tran, O.D./Dr. Vu Lam, O.D. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that the final determination can only be made when the claim is processed.

_____

Signature (Patient or Guardian) Date

DILATED FUNDUS EXAM

- A temporary enlargement of the opening of the eye (dilation of the pupil) is part of a comprehensive eye exam that allows the doctor to detect diseases and disorders in the back of the eye (peripheral retina). The side effects of the eye drops used to dilate the pupil include blurred near vision and sensitivity to light for 4-6 hours. This procedure is recommended as a baseline for all patients, especially those who have high amounts of nearsightedness, episodes of flashes or floaters, recent head trauma, or systemic diseases such as diabetes and hypertension.

  ☐ YES, I want a dilated exam. There will be an **additional charge if you do not have insurance.**

  ☐ NO, I do not want a dilated exam

WELLNESS RETINAL IMAGING

- Retinal imaging is offered at our office as another way to detect diseases and disorders in the back of the eye. Although this advanced technology is a great tool in the early detection of many eye diseases, it cannot detect abnormalities outside the photographic field. Please refer to the wellness retinal imaging form for a description of this procedure. There is an additional **$35 FEE** for the screening. **PLEASE CHECK YES OR NO** if you are interested in this procedure.

  ▢ YES, I want to have retinal photos taken of my eye for documentation.

  ▢ NO, I do not wish to have retinal photos taken.

EMAIL AND TEXT CONSENT

- We are happy to provide our patients with the option to communicate via email and text. Communications may include, but are not limited to, appointment reminders, scheduling reminders, billing statements, patient satisfaction surveys, and patient review requests..

  You may choose to discontinue your participation in our communication system at any time simply by emailing us at contact@envision2020.net or replying “STOP” to a text message from us. Standard text messaging rates may apply.

  We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

  Email:_____

  Cell phone:_____

  Please sign below to indicate that you agree to allow us to use this information in providing your services.

_____

Signature (Patient or Guardian) Date