

WELCOME TO OUR OFFICE

Today's date: _____ Referring Physician: _____ Family Physician _____

Name _____ Date of Birth: ____/____/____ Age: _____ Male Female

Address: _____ Apt #: ____ City: _____ State: ____ Zip: _____

Phone #: () _____ Home/Cell Day Time #: () _____ Work /Cell

SS #: _____ Marital Status: Married Single Widowed Other _____

Employed full time Employed part time Retired Student Other

Patient's Employer: _____ Phone #: () _____

Occupation: _____ Hobbies: _____ Date of last exam: _____

Medical insurance company: _____ Vision plan: _____

What is the purpose of your visit today? _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below.

Email address: _____

Note: All patient information is kept strictly confidential. Your information is NEVER shared.

Person Responsible (Guarantor) Name: _____ Phone #: _____

Address: _____ City: _____ St _____ Zip _____

Social Security number: _____ Date of Birth: _____

Relationship to patient (mother, father, etc.): _____

How did you hear about our office? (select all that apply)

Patient: Name _____ Marketing mailer Insurance

Professional: Name _____ Walk in

Co-Worker: Name _____ Yellow pages

Personal & Family Medical History:

	Self	Medication	Family		Self	Medication	Family
Allergies	Yes No	Yes No	Yes No	Glaucoma	Yes No	Yes No	Yes No
Asthma	Yes No	Yes No	Yes No	Eye diseases	Yes No	Yes No	Yes No
Arthritis	Yes No	Yes No	Yes No	Heart disease	Yes No	Yes No	Yes No
Cancer	Yes No	Yes No	Yes No	Eye injury	Yes No	Yes No	Yes No
Eye surgery	Yes No	Yes No	Yes No	High blood pressure	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No	Cataracts	Yes No	Yes No	Yes No

Authorization: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ **Date:** _____



Navarre Family Eye Care is committed to caring for our patient's complete ocular health. Here at **Navarre Family Eye Care** our patients receive a **Comprehensive Eye Health Examination**. Our doctors are trained and certified to diagnose and treat most ocular infections, injuries and diseases.

As a courtesy to our patients, we are happy to file with your vision plan and/or medical insurance company.

Routine Vision Exams will be filed to your vision plan (VSP, EyeMed, Davis, etc) if applicable. A routine vision exam means there is **no medical complaint or diagnosis**. Routine exams include diagnosis include nearsightedness, farsightedness, presbyopia, and include a prescription for glasses and/or contact lenses.

However, should you have a medical complaint or diagnosis (dry eyes, floaters, cataracts, glaucoma, diabetes, "pink eye", foreign body, etc), your exam is no longer considered routine. This means **Navarre Family Eye Care** is **required** to bill today's examination to your medical insurance. This is why we request a copy of both your medical insurance and vision plan cards.

Thank you,

Doctors and staff of Navarre Family Eye Care

I have read and understand when my Vision Plan will be billed and when my Medical Insurance will be billed by Navarre Family Eye Care.

Signature

Date



Navarre Family *Eye Care*

Dr. Carl Spear

Dr. Dustin Grubbs

Dr. Neil Hook

Navarre Family Eye Care offers a state of the art digital scanning technology that allows us to view the inside of your eye without the use of dilation drops. The **OPTOMAP** allows us to evaluate your retina for problems such as macular degeneration, retinal detachments, glaucoma, and diabetic retinopathy. The scanning system is completely safe for kids and adults and allows you the unique opportunity to see inside your own eye just at the doctor sees it.

Dilated Exam	OPTOMAP Exam
1. Blurred near vision for 4-6 hours	1. NO blurred vision
2. Light sensitivity for 4-6 hours	2. NO light sensitivity
3. Longer office visit to wait for drops to take effect	3. Takes less than 2 minutes to process
4. Only the doctor can see your retina	4. You can see your own retina

Early Detection is Crucial!!

Our doctors recommend that ALL patients have a thorough examination of their retina every year. Without the **OPTOMAP** or a dilated examination, the doctor cannot fully assess the health of your eye. Unfortunately, the **OPTOMAP** is not covered by insurance companies. So there is a nominal charge of \$29.00 for the **OPTOMAP**. In some rare cases, dilation may still be required.

_____ I elect to have a digital photo of my retina today. (\$29.00)

_____ I prefer a dilated exam of my retina, and are aware of the side effects above.

Patient Signature

Date

FINANCIAL RESPONSIBILITY STATEMENT

We will be happy to service you in accordance with your medical insurance/vision benefit. However, in the event the Plan Sponsor determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

Medical Insurance

1st-Primary Insurance:

Insurance Name: _____ Policy #: _____

Policyholder's Name: Self Other: _____

Date of Birth ____/____/____ Policyholder's SS#: _____

Relationship to Patient (spouse, parent, etc...) _____

2nd-Secondary/Supplement Insurance:

Insurance Name: _____ Policy #: _____

Policyholder's Name: Self Other: _____

Date of Birth ____/____/____ Policyholder's SS#: _____

Relationship to Patient (spouse, parent, etc....) _____

Vision Plan:

Insurance Name: _____ Policy #: _____

Policyholder's Name: Self Other: _____

Date of Birth ____/____/____ Policyholder's SS#: _____

Relationship to Patient (spouse, parent, etc....) _____

Some medical insurances will **not** pay for the refractive part of any eye exam. If a refraction (part of exam that determines your need for glasses) is necessary during the exam your insurance will disallow it, stating it is not a covered benefit. Therefore, the patient will be responsible for the refraction charge.

Patient/Guardian signature: _____ Date _____

Please have **ALL INSURANCE** card(s) ready for photocopying when forms are completed.

All Co-pay's and non covered service fees will be collected upon **Check-out**