

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 SS# \_\_\_\_\_ Emergency Contact & Phone Number \_\_\_\_\_  
 Email address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Whom may we thank for referring you to our practice? \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Doctor \_\_\_\_\_

**Personal Medical Information: Do you currently, or have you had any problems in the following areas:**

- |  |   |
|--|---|
| <input type="checkbox"/> Ears, Nose, Mouth, Throat                           | <input type="checkbox"/> Integumentary (skin, breasts)                      |
| <input type="checkbox"/> Cardiovascular/Vascular (heart)                     | <input type="checkbox"/> Neurological (headaches, numbness)                 |
| <input type="checkbox"/> Respiratory (lungs)                                 | <input type="checkbox"/> Psychiatric (mental, depression, anxiety)          |
| <input type="checkbox"/> Gastrointestinal (stomach, intestines, liver)       | <input type="checkbox"/> Endocrine (diabetes, thyroid)                      |
| <input type="checkbox"/> Genitourinary (kidneys, urinary/reproductive tract) | <input type="checkbox"/> Lymphatic/Hematologic (blood, lymph node)          |
| <input type="checkbox"/> Musculoskeletal (arthritis, muscles, bones)         | <input type="checkbox"/> Allergic/Immunologic (allergies, immune disorders) |
| <input type="checkbox"/> Surgeries (what type & when) _____                  |   |

Are you in good health? Yes  No

Do you have any allergic reactions to medications or other substances? Yes  No

If yes, please list \_\_\_\_\_

Name of primary care physician and phone number \_\_\_\_\_

Do you smoke? Yes  No  How much? \_\_\_\_\_

Do you drink alcohol? Yes  No  How much? \_\_\_\_\_

Do you use other substances? Yes  No

Do you take medications? Yes  No  Please list \_\_\_\_\_

**Have you or your blood relatives had any of the following conditions?**

	YOURSELF	FAMILY		YOURSELF	FAMILY
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lazy Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other condition(s) not listed above: \_\_\_\_\_

**Do you experience any of the following:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Floating Spots | <input type="checkbox"/> Dryness        | <input type="checkbox"/> Redness                | <input type="checkbox"/> Burning          |
| <input type="checkbox"/> Itchy/Scratchy | <input type="checkbox"/> Eye Injuries   | <input type="checkbox"/> Eye Surgeries          | <input type="checkbox"/> Eye Infections   |
| <input type="checkbox"/> Wear Glasses   | <input type="checkbox"/> Wear Contacts  | <input type="checkbox"/> Interested in Contacts |   |

If you are having any other eye problems at this time, please explain  
 \_\_\_\_\_

Are you interested in laser vision correction? Yes  No

## Financial Policies

### Insurance:

We are pleased to accept many vision and medical insurance plans. It is your responsibility to know what insurance plans provide your coverage and provide us with all the necessary information before services are rendered. **Claims cannot be re-processed to insurance after the date of service.**

As a courtesy to you, we will gladly submit claims directly to your insurance company. While we will make our best effort to verify your insurance coverage before providing services to you, this is by no means a guarantee that your insurance will actually pay your claim. **In the event that your insurance company does not pay your claim, whether due to an unmet deductible, a requirement for Primary Care Physician (PCP) referral, or any other reason, you agree to personally and promptly pay any balance owed.** We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Copayments and any non-covered charges are due on the date of service, unless other specific arrangements have been made in advance. All insurance copayments are non-refundable.

### Eyewear:

**All eyewear purchases require a minimum 50% non-refundable deposit before orders will be placed; this deposit will not be refunded if the order is cancelled.** Any order with a balance due after 90 days from the date glasses are ready for pickup will be considered canceled. **Eyewear purchases are non-refundable.** Manufacturers' warranties cover lenses and frames for one (1) year after dispensing against defects in materials and workmanship; minor cosmetic flaws due to normal wear and tear and breakage due to abuse are explicitly excluded. Lenses with scratches significantly interfering with vision may be replaced one time only during the first year of use at our sole discretion; scratching due to abuse is explicitly excluded.

Patients who are unable to adapt to Progressive Addition Lenses (PALs) after a reasonable effort will be afforded the opportunity to have their lenses replaced with a lined bifocal or single vision lens at their option and our expense, provided their concerns are brought to our attention within thirty (30) days of dispensing. No refunds will be made in this situation.

Patients who are unsatisfied with an eyewear prescription provided by this office will be seen for a courtesy Rx check, provided they bring their concerns to our attention within thirty (30) days of dispensing. If the prescription requires modification, we will replace the lenses at our expense.

**Different terms and conditions may apply to eyewear provided through vision insurance plans, as dictated by the insurance company. Please ask for details about your specific insurance, if applicable.**

### Outside prescriptions:

We are happy to fill outside prescriptions. **If the prescription is dated more than 6 months prior to the order date, any Rx changes will be at the patient's expense.** If the prescription is six months old or less, we will honor a Dr.'s change of Rx one time only, if the new Rx is presented to us within thirty (30) days of dispensing of the eyewear in question. After 30 days or one remake any changes will be at the patient's expense.

### Contact Lenses:

Contact lens purchases require payment in full before orders can be placed. Contact lenses cannot be returned for refund, but can be exchanged in the event of prescription change, provided the original boxes are unopened and not defaced in any way.

Our office accepts cash, checks, MasterCard, Visa, American Express and Discover. **Returned checks are subject to a \$35.00 fee.**

**By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services.** I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or other phone numbers listed to discuss financial matters related to this form. Furthermore, I authorize the release of any medical or other information necessary to process this claim and authorize the vision benefits otherwise payable to me to be paid directly to McAlear Eye Care.

### **HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE**

\_\_\_\_\_ (Initial here), I have been shown the Notice of Privacy Policy (the "Policy") of this provider and have been offered a copy of such policy to keep for my records.

### **I have read the above conditions of treatment and agree in content:**

Patient's Name: \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient (if other than patient) \_\_\_\_\_