HERTZOG FAMILY EYE CARE

Welcome to our office

PATIENT INFORMATION

Date: ____________________

Name: ____________________

Street: ____________________

City: ____________________

State: __________ Zip Code: __________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

Email Address: ____________________

May we email you occasional news, updates and/or special offers? ◯ Yes ◯ No

Patient's SSN: ____________________

Date of Birth: __________ Age: _____

Sex: ◯ M ◯ F

Employer (or School): ____________________

Occupation (or Grade): ____________________

Spouse (or Parent's Name): ____________________

What brings you to see us today?

____

____

____

____

If this is your first visit, how did you hear about us?

- ◯ Friend or Relative: Who? ____________________
- ◯ Another Doctor
- ◯ Insurance List
- ◯ Sign/Building
- ◯ AT&T Yellow Pages
- ◯ Magazine Ad: Which? ____________________
- ◯ Other: ____________________

INSURANCE • PREFERRED PAYMENT

Vision Plan: ____________________

Subscriber Name: ____________________

Subscriber SSN: ____________________

Subscriber Birth Date: ____________________

Primary Medical Insurance: ____________________

Subscriber Name: ____________________

Subscriber SSN: ____________________

Subscriber Birth Date: ____________________

How would you like to provide payment today?

◯ Cash ◯ Check or Debit Card ◯ Credit Card

◯ Flexible Spending Account

WARRANTY • SPECIAL INTEREST • REFERRALS

Your satisfaction is very important to us. We offer a one-year warranty on all eyewear, as well as a satisfaction guarantee on all contacts. If you are ever dissatisfied with the comfort or performance of your contacts, or if your prescription changes mid-box, we'll be happy to exchange your remaining supply.

Please check all that apply.

◯ I am interested in prescription or non-prescription sunglasses, and would like information on 2nd pair savings and vision plan discounts.

◯ I would like to know if I am a good candidate for Laser Vision Correction Surgery (LASIK).

◯ I would like to refer a family member or friend.
(We always appreciate referrals!)

____

____

____

____

OUR MISSION

The mission of Hertzog Family Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority.

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Current Medications (Rx or OTC):

____

____

____

Allergies to medications? ◯ Yes ◯ No

If so, what medications? ______________________________

____

____

Have you ever experienced, been diagnosed with or treated for health problems in any of the following areas?

	Yes	No
Allergies	◯	◯
Arthritis	◯	◯
Blood/Lymphatic	◯	◯
Cancer	◯	◯
Cholesterol	◯	◯
Diabetes	◯	◯
Digestive	◯	◯
Ears/Nose/Throat	◯	◯
Endocrine	◯	◯
Eczema/Rashes	◯	◯
Genital-urinary	◯	◯
High Blood Pressure	◯	◯
Integumentary (Skin)	◯	◯
Kidney	◯	◯
Muscle/Bone	◯	◯
Neurological	◯	◯
Psychological	◯	◯
Respiratory	◯	◯
Sinus	◯	◯
Thyroid	◯	◯
Unusual Weight Loss/Gain	◯	◯

Have you had any surgeries? ◯ Yes ◯ No

Do you use cigarettes/tobacco, alcohol or other addictive substances? ◯ Yes ◯ No

If you answered yes to the above, please explain:

____

____

____

____

PATIENT EYE HISTORY

Date of Last Eye Exam: ______________________________

Do you currently wear contact lenses? ◯ Yes ◯ No

If so, what kind? ______________________________

Are you satisfied with the vision and comfort of your contact lenses? ◯ Yes ◯ No

Are you satisfied with the vision and comfort of your current glasses? ◯ Yes ◯ No

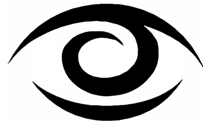
Have you ever experienced, been diagnosed with, or been treated for any of the following?

- ◯ Cataracts
- ◯ Corneal Abrasions
- ◯ Crossed Eye/Eye Turn
- ◯ Double Vision
- ◯ Eye Infections
- ◯ Eye Injury
- ◯ Floaters/Spots in Vision
- ◯ Glaucoma
- ◯ Dry Eyes
- ◯ Iritis/Uveitis
- ◯ Allergy Problems
- ◯ Lazy Eye
- ◯ Macular Degeneration
- ◯ Retinal Detachment
- ◯ Sunlight Sensitivity
- ◯ Excessive Tearing
- ◯ Other Eye Disorders: ______________________________

FAMILY HISTORY

Is there a blood-relative history of any of the following?

	Yes	Relationship
Blindness	◯	
Cataracts	◯	
Corneal Problems	◯	
Glaucoma	◯	
Lazy Eye	◯	
Macular Degeneration	◯	
Retinal Problems	◯	
Arthritis	◯	
Cancer	◯	
Diabetes	◯	
Heart Disease	◯	
High Blood Pressure	◯	
Kidney Disease	◯	
Lupus	◯	
Thyroid Disease	◯	
Other	◯	



HERTZOG FAMILY EYE CARE

FINANCIAL POLICY • INSURANCE • NOTICE OF PRIVACY PRACTICES

PAYMENT • INSURANCE FILING

Payment in full is due at the time services are rendered. Vision plans and health insurance can sometimes cause confusion, so we are happy to file your insurance for you. However, after 90 days, you (the patient) may be responsible for any balance on your account not paid by the insurance company. (See addendum on next page)

CONTACT LENS EVALUATIONS • REFRACTION

Contact lens wearers are at greater risk for infection and corneal tissue damage, and therefore a proper evaluation is essential. Refraction is the clinical test in which the doctor measures the eye's visual prescription for spectacles and/or contact lenses.

Some insurance plans do not cover the cost for these tests. Please let us know if you would like us to discuss these fees prior to your examination.

NOTICE OF PRIVACY PRACTICES

You have the right to review our notice of privacy practices [Health Insurance Portability & Accountability Act of 1996 (HIPAA)]. You may obtain a current copy of your notice of privacy practices at any time.

Responsible Party's Signature:____ Date: ____________________

I release my medical information to (Name and Relation):____
____

Dil ated Fundus Examination

Hertzog Family Eye Care considers the dilation of the pupils an important part of a complete eye examination. The purpose of pupil dilation is to enable the doctor to examine the inside of the eye more thoroughly. It helps with the early detection of eye diseases such as cataracts, glaucoma, macula degeneration, and other retinal diseases. It helps with detection and monitoring of systemic diseases such as high blood pressure, diabetes, and high cholesterol. Drops are used dilate the pupil which will cause temporary light sensativity and difficulty with reading or near work for 3-6 hours. If you do not have a driver today, you may schedule the dilation for another time. It may be necessary for patients showing signs of eye disease or young children to be dilated today's visit. Hertzog Family Eye Care recommends that patients diagnosed with diabetes, previously diagnosed with any retinal disease, or over the age of 50 be dilated every year.

◯ Yes, I DO want to be dilated today. ◯ No, I DO NOT want to be dilated today.

Patient/Gaurdian's Signature____