

Patient Information	
Name (legal name)	
Date of Birth	
Address	
City, State, Zip	
Phone	
Email	
Vision Plan MEDICAL POLICY	
Insurance Carrier	
ID (all #s/letters)	
Group #	
Primary Member's Information (Subscriber Member)	
Legal Name	
Date of Birth	
Last 4 of SS	
Primary HealthCare Provider <input type="checkbox"/> <i>No</i>	
Name of Clinic	
Primary Care Provider	
Address/Location	
Telephone	
Fax	
Reason for Examination	
<input type="checkbox"/> Comprehensive Eye Examination <input type="checkbox"/> Contact Lens Evaluation/Updated Contact Lens RX <input type="checkbox"/> Diabetic Eye Examination <input type="checkbox"/> Office Visit (red eye, floaters, eye pain, etc.) <input type="checkbox"/> Neuro-Optometric Evaluation <input type="checkbox"/> Specialty Contact Lenses	

Current/History of Eye Problems			
Flashes of light	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye strain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Floaters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watery eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itchy eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye turn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Light sensitivity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			
Glasses wearer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact lens wearer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last eye exam?		(MM/YYYY)	
Have you been dilated before?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Medical Eye History		Self	Family <input type="checkbox"/> N/A
Glaucoma/Glaucoma Suspect		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cataracts		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Macular Degeneration		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blindness		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retinal Detachment		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Corneal Ulcer		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Past Eye Surgeries		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical History		Self	Family
* Check "Y" if the condition applies to you; <input type="checkbox"/> Adopted/Unknown Fam Hx			
General	Weight change (10 lbs. in last year)	<input type="checkbox"/> Y	
	Appetite change	<input type="checkbox"/> Y	
	Pregnant/Nursing	<input type="checkbox"/> Y	
Endocrine	Type 1 Diabetes	<input type="checkbox"/> Y	
	Type 2 Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> Y <input type="checkbox"/> N
	Hypothyroid (Low)	<input type="checkbox"/> Y	<input type="checkbox"/> Y <input type="checkbox"/> N
	Hyperthyroid (High)	<input type="checkbox"/> Y	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular	Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> Y <input type="checkbox"/> N
	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> Y <input type="checkbox"/> N
	High Cholesterol	<input type="checkbox"/> Y	
Ear, Nose, & Throat	Cold symptoms	<input type="checkbox"/> Y	
	Hearing changes	<input type="checkbox"/> Y	
Respiratory	Asthma	<input type="checkbox"/> Y	
	Loud snoring	<input type="checkbox"/> Y	
	Sarcoidosis	<input type="checkbox"/> Y	
Neurological	Headaches	<input type="checkbox"/> Y	
	Concussion	<input type="checkbox"/> Y	
	Multiple sclerosis	<input type="checkbox"/> Y	
	Epilepsy/seizures	<input type="checkbox"/> Y	
	Stroke	<input type="checkbox"/> Y	
	Alzheimer's disease	<input type="checkbox"/> Y	
Psychiatric	ADHD	<input type="checkbox"/> Y	
	Anxiety	<input type="checkbox"/> Y	
	Depression	<input type="checkbox"/> Y	
	Sleep Problems	<input type="checkbox"/> Y	
Genitourinary/ Kidney	Prostate Cancer	<input type="checkbox"/> Y	
	Kidney Disease	<input type="checkbox"/> Y	
Musculoskeletal	Arthritis	<input type="checkbox"/> Y	
	Myasthenia gravis	<input type="checkbox"/> Y	
Gastrointestinal	Colitis/Crohn's	<input type="checkbox"/> Y	
	Acid reflux	<input type="checkbox"/> Y	
Skin	Lupus	<input type="checkbox"/> Y	
	Rosacea	<input type="checkbox"/> Y	
Blood/lymph	Sickle cell disease	<input type="checkbox"/> Y	
	Bleeding disorder	<input type="checkbox"/> Y	
Allergic/Immunologic	HIV Positive	<input type="checkbox"/> Y	
	History of Shingles	<input type="checkbox"/> Y	
	Lyme's disease	<input type="checkbox"/> Y	
	Sjogren's Syndrome	<input type="checkbox"/> Y	
	Seasonal allergies	<input type="checkbox"/> Y	
Other			
List Eye Drops	<input type="checkbox"/> None		
List of ALL Medications	<input type="checkbox"/> None		
Allergies to Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No List:		
Eye Surgeries	<input type="checkbox"/> None <input type="checkbox"/> Yes (list) -		
List of Injuries/Surgeries	<input type="checkbox"/> None <input type="checkbox"/> Yes (list) -		
Tobacco use?	<input type="checkbox"/> Yes-current <input type="checkbox"/> Yes - Prior <input type="checkbox"/> No		
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No		



SECTION 1 - HIPAA PRIVACY

I understand that Wallerich Eye Care, LLC (WEC) may use and disclose necessary personal health information (PHI) to another party to permit Dr. Wallerich & his associates to perform administrative duties, provide me with eye care services and products, and to process my vision/medical benefit claims. Please notify staff if you would like a copy of "Notice of Privacy Practices".

SECTION 2: BUSINESS PRACTICE POLICIES

In order for WEC & third-party billing services to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any phone number/address I have provided during all visits for billing and reminder/recall eye care services. **If you plan on using insurance benefits, insurance information must be presented before time of service.** If you have not presented your insurance or have any questions about co-pays or fees, please address the staff now.

I understand that my eye exam and any optional contact lens evaluation or fitting copayments are due at the time of service today. I have 60 days to complete the contact lens evaluation process unless otherwise specified. I also understand that fees for services are non-refundable/non-negotiable. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered services.

I authorize the release of my information for WEC or a third-party insurance billing service to file insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute.

SECTION 3: ROUTINE VISION CARE vs. ROUTINE MEDICAL EYE CARE

The Eye Care Industry is under the regulation of many government agencies and is subject to ever-changing laws dictating the coding and reporting of each visit with a healthcare professional. The purpose of these regulations/laws is to ensure your visit is of the highest quality. WEC continues to meet those high standards and quality control measures. In order to do so, your provider must be specific regarding the nature of each visit and must accurately & specifically code your visit based upon clinical findings and concerns addressed. The doctor then determines if the vision problems you currently have are normal or are disease-related changes. The doctor may order additional testing, refer you to another doctor or specialist, or advise of other treatments as needed.

If a medical eye concern is discovered and/or addressed (based upon your concerns, systemic medical history, prior eye history, etc.) during your routine eye exam today, the exam must be submitted to your medical insurance carrier. This may have copays or may have fees that Wallerich Eye Care has no control of, as your insurance carrier ultimately determines associated costs with your visit.

Please sign below to confirm you understand your routine eye exam today may be billed to your vision plan or medical insurance. By signing below, you acknowledge & confirm WEC's notice of privacy practices, business practice policies and that you have reviewed your medical insurance/vision plan and understand how each applies to your insurance plan benefits.

Patient/ Guardian Signature:		Date:	
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SECTION 4: INFORMED CONSENT FOR DILATION and/or OPTOS IMAGING

The dilated eye exam allows the doctor to perform a more thorough eye health exam. Dilation is recommended for the following patients: new patients, a change/increase in floaters or flashes of light, highly nearsighted, unexplained headaches, vision loss, head trauma or other medical conditions (diabetes, hypertension, etc.). A dilated eye exam requires the use of eye drops that take about 10-25 minutes to dilate your pupils. This may cause light sensitivity for 1-5 hours and blurry near vision for 1-3 hours. This is a covered service for your eye exam.

An OPTOS image does not require dilation but allows the optometrist to check the retinal eye health of the back of the eye. In certain instances, dilation still may be recommended/advised pending the results of the OPTOS image, past medical/eye history, or the patient's concern/reason for the visit. The cost is \$35.00 (insurance often does not cover copay).

SECTION 5: INFORMED CONSENT FOR EDUCATIONAL RESEARCH/CASE PRESENTATIONS

Dr. Wallerich & associates provide educational seminars for skilled nursing home staff, eye care professionals, physicians, and advanced practice providers nationally on topics regarding geriatric eye care, neuro-ophthalmic disease, anterior segment disease, traumatic/acquired brain injuries, and other topics. Case reports are presented with photos, diagnostic imaging, and clinical information to advance the learning of participants to improve patient care nationwide. Personal health information is removed from all imaging/reports to protect private patient information.

How did you hear about our practice (check all that apply)?

- Friend Family Member Healthcare Provider Online Target Ins: _____

Please provide the name of the referrer? First/Last Name: _____