

Will Your Eye Exam today be ...

Routine?

A routine eye exam is done yearly to check for vision changes detect any eye disease to pay for eyeglasses and contact lenses. This would include a refraction to measure your vision prescription, a dilated retinal exam and a variety of other tests. Your vision plan will be billed.



Medical?

If you are visiting our office with a medical complaint, injury, infection, inflammation or chronic eye disease, we will file your eye examination to your medical insurance carrier. You will be responsible for applicable co-pays, deductibles and refraction. We can still check you for the need for glasses or contact lenses even through we are evaluating a medical problem.

What is the main reason for your visit today? _____

Any updates including address, phone numbers or medications that we should know about? _____

Height _____ Weight _____ lbs

Do you drink alcohol? No Occasionally / Socially 1 / day 2-3 / day 4+ / day
Do you smoke? No Occasionally / Socially , 1/2 pk / day 1 pk / day 2 pk / day
Are you planning to get new glasses today? Yes No **Contacts:** Yes No

What type of examination would you like us to perform at your appointment?

- EYE EXAM** (Routine Well-Patient)
A **routine well-patient eye exam** includes a refraction to update your eyeglass or contact lens prescription and a dedicated health examination.
Your vision plan (i.e., **EYEMED, VSP**) will be billed.
- EYE EXAM** (Medically Oriented)
A **medically-oriented eye exam** includes all of the above but the **reason for the visit** is medical in nature (i.e., allergies, cataracts, glaucoma, macular degeneration, infections, dry eye syndrome.)
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.
- MEDICAL OFFICE VISIT** (Problem Focused)
A **medical problem-focused office visit** consists of the doctor evaluating a specific medical problem only such as eye allergies, glaucoma, infections, etc. and not necessarily checking your for eyeglasses. This typically is not a full examination unless you are a new patient to the practice.
Your regular health insurance (i.e., **AETNA, BCBS, MEDICARE** etc.) will be billed.

Patient Name Patient or Guardian Signature Date

Medical Information Release Form

I give University Eye Care authorization to release information regarding my health to the following people (i.e. spouse, siblings, parents, etc.)

Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name _____ Relation _____

Name _____ Relation _____

If our office cannot reach you personally, may we leave protected health information, (i.e. appointment dates, returned messages, etc.) by the following methods?

With a family member: Yes _____ No _____

Home answering machine: Yes _____ No _____

Cellular Voice Mail: Yes _____ No _____

By mail to home address: Yes _____ No _____

By email: Yes _____ No _____

Patient or Guardian Signature _____ Date: _____

GLENN A. ALTMAN, D.O., P.A.

PATIENT REGISTRATION

Thank you for choosing University Eye Care.

Please take a moment to fill out the information below as completely as possible.

Today's Date: _____

Patients First Name:		Middle Initial:	Last Name:	
Local Address:			City, State & Zip Code:	
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Phone:		Work Phone:	Cell Phone:	
E-mail Address:			Social Security No: (For insurance & record keeping only)	
Employer:			Occupation:	
Employment Status: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Student				
Guarantor Full Name / Person Responsible for Payments:			Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	
Communication Preference: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone:			May we leave messages on your home/cell phone?	
Whom may we thank for referring you to us:				

If you are coming in to have a medical complaint, problem or condition addressed (**Example: eye infection, itchy eyes, dry eyes, cataracts, floaters, diabetes, glaucoma, trauma**) **we are required to bill your medical insurance** for your eye exam. **Most often, we can still check your vision and measure you for glasses** even though we are evaluating a medical problem and billing your medical plan. You will be responsible for applicable co-pays and refraction fees. Vision plans, (i.e., VSP, Eyemed) **do not** cover eye exams in which significant medical complaints are addressed. If you are coming in for a routine vision exam to have your glasses or contact lenses updated, **we will bill your vision plan.**

Vision Insurance Co. Name:	Vision Insurance ID / Contract Number:
Medical Insurance Co. Name:	Medical insurance ID / Contract Number:
Policy Holder / Insured's Full Name:	Patient's Relation to Insured:
Policy Holder / Insured's Date of Birth:	Insured's Employer Name:

I acknowledge that I have received a copy of Glenn A. Altman, D.O., P.A. HIPAA Notice of Privacy Practices.

Signature: _____ **Date:** _____

Name: _____ Date: _____

Do you currently have any of the following conditions?

	YES	NO	Please CIRCLE or LIST specific condition:
Allergies / Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	allergies, rheumatoid arthritis, Lupus _____
Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	asthma, COPD, emphysema, chronic bronchitis _____
Ear / Nose / Throat problems	<input type="checkbox"/>	<input type="checkbox"/>	sinus problems, hearing loss, ear infections _____
Heart / Cardio problems	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure, high cholesterol, irregular heart beat, congestive heart failure _____
Constitutional problems	<input type="checkbox"/>	<input type="checkbox"/>	fever, recent weight loss or gain, fatigue _____
Endocrine problems	<input type="checkbox"/>	<input type="checkbox"/>	diabetes, thyroid, kidney _____
Gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	heart burn, IBS, vomiting, diarrhea _____
Genitourinary problems	<input type="checkbox"/>	<input type="checkbox"/>	pain, blood in urine, discomfort, discharge _____
Infectious problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV, hepatitis, tuberculosis _____
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	rashes, dryness eczema _____
Musculoskeletal problems	<input type="checkbox"/>	<input type="checkbox"/>	aches, joint pain, swelling, osteoarthritis _____
Neurologic problems	<input type="checkbox"/>	<input type="checkbox"/>	headaches, numbness, weakness _____
Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	depression, anxiety, bipolar _____
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	

Race: American Indian Asian
 African American / Black Hispanic
 Native Hawaiian / Pacific Islander Caucasian / White

Ethnicity: Hispanic or Latino Native Hawaiian / Pacific Islander
 Hispanic Non-Hispanic Other _____

Please list any medications you take? (Include eye medications and or vitamins): _____

Please list any drug allergies: _____

Do you currently have, or been diagnosed with any of the following conditions: (PLEASE CHECK)

- Retinal detachment Glaucoma Cataracts Strabismus (eye turn) None
 Amblyopia (lazy eye) Macular degeneration Diabetic retinopathy Dry Eye Syndrome

Any past trauma to the eye? Yes No Nature of injury _____

Have you had any eye surgery such as cataract surgery, laser surgery or eye muscle surgery? If so, please list procedure and year performed. No
 Rt _____ Lt _____

Do you have a family history of any of the following: No

- Glaucoma Strabismus (eye turn) Macular degeneration Retinal detachments Cancer / Melanoma Diabetes

Primary Physician's Name: _____ Pharmacy: _____

Are you interested in LASIK I Laser vision correction? Yes No

ADVISEMENT:

Please be advised, our doctor dilates your pupils as a part of a complete eye health examination. This is not an optional part of the exam. This may cause light sensitivity and temporary blurry vision. Caution should be taken when driving. Protective sunglasses are available.