PATIENT INTAKE & HEALTH HISTORY

PATIENT LEGAL NAME:	DOB:	DATE:

YOUR MINIMUM EXAM COPAYMENT TODAY COULD BE: ROUTINE $ _____ MEDICAL $ _____ CONTACT FIT $ _____ (IF APPLICABLE)
FINAL CHARGES WILL BE DETERMINED ONCE YOUR EXAM IS COMPLETED.

PLEASE MARK YOUR METHOD OF PAYMENT: CASH: _____ CHECK: _____ DEBIT/CREDIT: _____

PATIENT INFORMATION

PREFERRED NAME	GENDER	AGE
PHONE (required) ☐ HOME ☐ MOBILE	ADDRESS 1	
EMAIL ADDRESS	ADDRESS 2	
*YOU WILL RECEIVE PERIODIC MESSAGES RELATED TO YOUR APPOINTMENT AND ORDER(S) BY TEXT AND EMAIL AND PROMOTIONAL MESSAGES BY EMAIL ONLY. IF YOU DO NOT WISH TO RECEIVE IMPORTANT MESSAGES BY TEXT OR EMAIL, THE ABILITY TO OPT-OUT IS PROVIDED WITHIN EACH EMAIL AND BY TEXT. TERMS & CONDITIONS AND PRIVACY POLICY AT HTTPS://AEGVISION.COM/PRIVACY-STATEMENT.	CITY, STATE, ZIP	
	EMPLOYER	
	OCCUPATION	
	SSN (IF INS. REQUIRES)	

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

PARENT/GUARDIAN FULL NAME	RELATIONSHIP TO PATIENT
DATE OF BIRTH	PRIMARY PHONE #
ADDRESS	EMAIL ADDRESS

VISION INSURANCE	MEDICAL INSURANCE
INSURANCE CARRIER	INSURANCE CARRIER
POLICY NUMBER	POLICY NUMBER
GROUP NUMBER	GROUP NUMBER
SECONDARY (IF APPLICABLE)	SECONDARY (IF APPLICABLE)

POLICYHOLDER INFORMATION (IF DIFFERENT FROM PATIENT)

NAME (AS SHOWN ON CARD)	ADDRESS
SSN (IF INS. REQUIRES)	CITY, STATE, ZIP
DATE OF BIRTH	PRIMARY PHONE #

PRIMARY CARE INFORMATION

PHYSICIAN NAME	PHONE #

☐ **BY CHECKING THIS BOX I AGREE TO HAVE MY RECORDS OR DIAGNOSIS INFORMATION SHARED WITH MY PHYSICIAN.**

PHARMACY INFORMATION

PHARMACY NAME	CITY & ZIP CODE

STATEMENT OF FINANCIAL RESPONSIBILITY

IN ORDER FOR MY EYECARE PROVIDER TO SERVICE MY ACCOUNT OR TO COLLECT ANY AMOUNTS I MAY OWE, I AGREE THAT I MAY BE CONTACTED AT ANY NUMBER OR ADDRESS I HAVE PROVIDED ABOVE OR DURING A PREVIOUS ENCOUNTER. I UNDERSTAND THAT MY EYE EXAM AND ANY OPTIONAL CONTACT LENS FITTING COPAYMENTS ARE DUE TODAY, AND GLASSES OR CONTACT LENSES MAY NOT BE DISPENSED IF THOSE COPAYMENTS ARE UNPAID. I ALSO UNDERSTAND THAT FEES FOR SERVICES ARE NON-REFUNDABLE AND NON-NEGOTIABLE, AND ANY CONTACT LENS PRESCRIPTIONS GIVEN ARE VALID FOR ONE YEAR PER FEDERAL LAW. 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 ITEMS, AS OUTLINED IN DETAIL ON MY RECEIPT, WHICH INCLUDES: THE SPECIFIC DATE OF SERVICE, DESCRIPTION OF EACH PROCEDURE/SERVICE, AND THE AMOUNT I AM RESPONSIBLE FOR PAYING OUT-OF-POCKET; I CERTIFY THAT I HAVE BEEN INFORMED OF ALL ITEMS AND COST. I AUTHORIZE THE RELEASE OF MY INFORMATION FOR MY EYECARE PROVIDER TO FILE ALL 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. MY EYECARE PROVIDER CAN ALSO SUPPLY ME WITH AN ITEMIZED STATEMENT WHICH I MAY SUBMIT TO MY INSURANCE CARRIER SHOULD I NEED TO SUBMIT FOR REIMBURSEMENT. I UNDERSTAND THAT ANY FOLLOW-UP APPOINTMENTS RELATED TO A CONTACT LENS EVALUATION ARE INCLUDED FOR THREE MONTHS AFTER THE INITIAL FITTING, AND SHOULD THERE BE ANY FOLLOW-UP APPOINTMENTS REQUIRED AFTER THE THREE MONTHS HAVE PASSED, I AM RESPONSIBLE TO PAY THE PROFESSIONAL SERVICE FEE. ADDITIONALLY, I KNOW THAT ANY OPTIONAL TESTING THAT I HAVE VERBALLY AGREED TO PAY FOR IS MY RESPONSIBILITY TO DO AS SUCH ON THE DATE OF SERVICE. SHOULD I RECEIVE A MEDICAL EXAMINATION, I UNDERSTAND THAT MY MAJOR MEDICAL INSURANCE WILL BE BILLED, AND I WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES, COINSURANCE, OR COPAYMENTS THAT MAY BE DUE.

☐ I HAVE READ AND UNDERSTAND THE STATEMENT OF FINANCIAL RESPONSIBILITY.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN): _____ DATE: _____

ATTENTION: Language assistance services, free of charge, are available to you. If you need these services, please let practice associates know, or contact the Section 1557 Coordinator at compliance@aegvision.com.

PATIENT NAME: _____ DOB: _____ DATE: _____

PATIENT MEDICAL INFORMATION

MANY MEDICAL CONDITIONS AND MEDICATIONS AFFECT THE EYES. PLEASE HELP THE DOCTOR BY FILLING OUT YOUR MEDICAL HISTORY AS COMPLETELY AS POSSIBLE.

PLEASE CHECK ALL OF THE CONDITIONS THAT APPLY TO YOU:

RESPIRATORY ISSUES	☐ YES	☐ NO	**HEMATOLOGIC CONDITIONS**	☐ YES	☐ NO	**EAR/NOSE/THROAT PROBLEMS**	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO	SICKLE CELL	☐ YES	☐ NO	SINUS PROBLEMS	☐ YES	☐ NO
EMPHYSEMA	☐ YES	☐ NO	HIGH CHOLESTEROL	☐ YES	☐ NO	DENTAL PROBLEMS	☐ YES	☐ NO
SKIN CONDITIONS	☐ YES	☐ NO	**ALLERGY/IMMUNOLOGY**	☐ YES	☐ NO	**NEUROLOGICAL DISORDER**	☐ YES	☐ NO
ECZEMA	☐ YES	☐ NO	HAY FEVER	☐ YES	☐ NO	MIGRAINE HEADACHES	☐ YES	☐ NO
ROSACEA	☐ YES	☐ NO	SJOGREN'S SYNDROME	☐ YES	☐ NO	MULTIPLE HEADACHES	☐ YES	☐ NO
ENDOCRINE DISORDER	☐ YES	☐ NO	RHEUMATOID ARTHRITIS	☐ YES	☐ NO	MULTIPLE SCLEROSIS	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	LUPUS	☐ YES	☐ NO	MYASTHENIA GRAVIS	☐ YES	☐ NO
THYROID DISORDER	☐ YES	☐ NO	**FEVER/FATIGUE/WEIGHT LOSS**	☐ YES	☐ NO	HEAD INJURY	☐ YES	☐ NO
GASTROINTESTINAL ISSUES	☐ YES	☐ NO	**MUSCULOSKELETAL CONDITIONS**	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
HEARTBURN	☐ YES	☐ NO	OSTEOPOROSIS	☐ YES	☐ NO	**KIDNEY/BLADDER PROBLEMS**	☐ YES	☐ NO
CARDIOVASCULAR CONDITIONS	☐ YES	☐ NO	**PSYCHIATRIC DISORDER**	☐ YES	☐ NO	**SEXUALLY TRANSMITTED DISEASES**	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	ANXIETY	☐ YES	☐ NO	**CANCER**	☐ YES	☐ NO
HEART FAILURE	☐ YES	☐ NO	DEPRESSION	☐ YES	☐ NO	**SURGICAL OPERATIONS**	☐ YES	☐ NO

HAVE YOU PREVIOUSLY HAD ANY EYE INJURIES, EYE SURGERIES OR EYE DISEASES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

HAVE YOU EXPERIENCED ANY FLOATERS, FLASHES OF LIGHT, BURNING, ITCHING, REDNESS, DRYNESS, DOUBLE VISION, UNUSUAL BLURRY VISION, FREQUENT STYES/CHALAZIONS, OR EXCESSIVE TEARING/WATERING? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:

DO YOU HAVE LIGHT SENSITIVITY OR ISSUES WITH GLARE WHILE OUTDOORS OR DRIVING? ☐ YES ☐ NO ☐ SOMETIMES

DO YOU HAVE ISSUES WITH GLARE OR HAVE EYE FATIGUE WHILE ON A COMPUTER? ☐ YES ☐ NO ☐ SOMETIMES

ARE YOU CURRENTLY BEING TREATED FOR ANY OTHER MEDICAL CONDITIONS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING HORMONES, VITAMINS, BIRTH CONTROL, ASPIRIN, OTHER ANTI-INFLAMMATORY, EYE DROPS, ETC.) : ☐ NONE

DATE OF LAST GENERAL HEALTH EXAM: _____ DATE OF LAST EYE EXAM: _____ PREVIOUS EYE CARE PROVIDER: _____

ARE YOU CURRENTLY PREGNANT OR NURSING? ☐ YES ☐ NO

DO YOU SMOKE OR USE TOBACCO? ☐ YES ☐ NO _____ LESS THAN 1 PACK A DAY _____ 1-2 PACKS A DAY _____ 2 PACKS A DAY

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO _____ SOCIAL _____ 1-2 DRINKS DAILY _____ ABOVE AVERAGE USE _____ DEPENDENCE

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO IF YES, PLEASE LIST: _____

CONTACT LENS INFORMATION

DO YOU CURRENTLY WEAR CONTACT LENSES? _____ ☐ YES ☐ NO IF YES, PLEASE LIST THE BRAND: _____

HOW MANY HOURS A DAY DO YOU WEAR CONTACTS? _____ HOW OFTEN DO YOU THROW AWAY YOUR LENSES? _____

DO YOUR EYES FEEL DRY WHILE WEARING CONTACTS? ☐ YES ☐ NO WHAT DO YOU USE TO CLEAN YOUR LENSES? _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING ILLNESSES?

BLINDNESS*	☐ YES	☐ NO	RELATIONSHIP: _____
CANCER*	☐ YES	☐ NO	RELATIONSHIP: _____
CATARACT	☐ YES	☐ NO	RELATIONSHIP: _____
COLOR BLINDNESS*	☐ YES	☐ NO	RELATIONSHIP: _____
DIABETES*	☐ YES	☐ NO	RELATIONSHIP: _____
GLAUCOMA*	☐ YES	☐ NO	RELATIONSHIP: _____
HEART DISEASE	☐ YES	☐ NO	RELATIONSHIP: _____
HIGH BLOOD PRESSURE*	☐ YES	☐ NO	RELATIONSHIP: _____
LAZY EYE*	☐ YES	☐ NO	RELATIONSHIP: _____
MACULAR DEGENERATION*	☐ YES	☐ NO	RELATIONSHIP: _____
RESPIRATORY DISEASE	☐ YES	☐ NO	RELATIONSHIP: _____
RETINAL DETACHMENT*	☐ YES	☐ NO	RELATIONSHIP: _____

**ADDITIONAL TESTING MAY BE COVERED THROUGH YOUR MEDICAL INSURANCE.*

HIPAA ACKNOWLEDGEMENT & EMERGENCY CONTACT FORM

Patient Name: _____ Date of Birth: _____

HIPAA is a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, other health care providers in addition to individuals known to the patient (including family members or caretakers). The AEG Vision Privacy Policy and Notice of Privacy Practices can be found on the company website for full details regarding how AEG and managed practices use, share, disclose, protect, and release your personal information.

I AUTHORIZE AEG VISION AND ITS MANAGED PRACTICES TO RELEASE THE FOLLOWING INFORMATION EITHER DURING OR FOLLOWING MY APPOINTMENT OR IN CASE OF AN EMERGENCY:

☐ Exam Notes ☐ Treatment Plans ☐ Merchandise Purchased ☐ All records
☐ Test Results ☐ Prescriptions

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL(S):

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**

_____

If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

I understand that authorizing the release of this health information is voluntary. I do not need to complete this form in order to proceed with treatment.

Patient Signature: _____ Date: _____
Authorized Representative/Parent: _____ Date: _____
Printed Name of Authorized Representative/Parent: _____
Relationship to Patient: _____

ATTENTION: Language assistance services, free of charge, are available to you. If you need these services, please let practice associates know, or contact the Section 1557 Coordinator at compliance@aegvision.com.

Patient Name: _____

Date of Birth: _____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS and NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have the legal authority to authorize the examination and treatment of the above-listed patient by AEG Vision managed practices. I understand that the examination and treatment may include the use of various exams or tests (including, but not limited to: comprehensive eye examinations, glaucoma testing, pupil dilation, and contact lens fitting), medications (including dilating or numbing agents and dry eye assessment drops), and other diagnostic procedures and tests normally provided in an optometry practice. If other procedures are required and not emergent in nature, then this will be explained to me by my provider. If this occurs, I will be asked to give additional written consent for these procedures.

I understand that my medical information provided by me, and collected during evaluation, including recordings (photographs, video, electronic), may be allowed under HIPAA to be collected, used, and disclosed only as necessary for:

- Treatment, payment, and healthcare operations purposes,
- Public health purposes or oversight activities, and
- Other purposes as required by law.

By agreeing to receive treatment:

- I authorize the examination and treatment of the patient as the legal representative (or self, if the patient).
- I acknowledge:
    - If this is my first visit to the practice that I have been provided to review a copy of the AEG Vision Notice of Privacy Practices.
    - I have the right to review the AEG Vision Notice of Privacy Practices before signing this form.
    - As provided in the Notice, the terms of the Notice may change. If we change our Notice, I am aware the Notice of Privacy Practices can be obtained from our website www.aegvision.com, or from the practice location, at any time.
- The Notice of Privacy Practices provides information about how we use and disclose health information about you. I consent to the collection and sharing of information as indicated above and the uses and disclosures detailed in the Notice of Privacy Practices, including releasing my medical information to my insurance company(s) as needed to process my insurance claim(s).
    - I understand that if I do not agree with the uses and disclosures detailed in the Notice of Privacy Practices, I have the right to request, in writing, that AEG Vision and its affiliated practices restrict how protected health information about me is used or disclosed, however, AEG Vision is not required and may not be able to agree to the request if disclosure is required by law or to comply with HIPAA.
- I understand this authorization for treatment applies and extends to subsequent appointments at this practice as well as other AEG affiliated practice locations.

I certify that I have read and understand the above statements and that I am providing my consent to treat.

_____	_____	_____	_____
Patient/Legal Representative Signature	Relationship to Patient	Date	AM/PM Time
_____	_____		
Legal Representative Name (Print)	Name of Patient (Print)		

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