Patient Information

Exam Date__/__/__

Last Name _____ First Name _____ M[ ] F [ ] Birth Date__/__/__
Address _____ City _____ State ___ ZIP _____
Preferred Phone # _____ Home Work Cell Secondary Phone # _____ Home Work Cell
Email Address _____ Employer _____ Occupation_____

Insurance Information

Medical/Vision _____ Group _____ Insured ID# _____
Insured Name _____ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child Insured DOB__/__/__
Medical/Vision _____ Group _____ Insured ID# _____
Insured Name _____ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child Insured DOB__/__/__

Medical and Ocular History

What is the reason for the exam today?

_____

_____

Do you or any of your blood relatives (ie Grandparents, Parents, Brother, or sister) have any of these conditions?

	Self	Relative	None		Self	Relative	None		Yes	No
Diabetes	[ ]	[ ]	[ ]	Glaucoma	[ ]	[ ]	[ ]	Do you see double?	[ ]	[ ]
Hypertension	[ ]	[ ]	[ ]	Cataracts	[ ]	[ ]	[ ]	Frequent headaches?	[ ]	[ ]
Thyroid	[ ]	[ ]	[ ]	Retinal Disease	[ ]	[ ]	[ ]	Are you pregnant?	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	Eye Surgery	[ ]	[ ]	[ ]	Eyes been dilated?	[ ]	[ ] Year?_____
Asthma	[ ]	[ ]	[ ]	Eye Injury	[ ]	[ ]	[ ]			
Cancer	[ ]	[ ]	[ ]	Other_____	[ ]	[ ]	[ ]	Primary Care Dr._____		

Please explain any positive findings: _____

_____

Are you taking any Medications (including eyedrops) prescription or over the counter? Please list: _____

_____

Do you have any allergies, medication or other? If Yes, please explain: _____

_____

Contact Lens History

What brand of contact lenses do you wear? _____ How often do you replace them? _____
Do you regularly sleep in them? _____ How do you clean them? _____
*See "Contact Lenses Fitting" for policies and pricing

Dilation: Dilating the eyes is an important way to look more at the health of the inside the eyes. Recommended intervals depends on certain ocular and systemic health criteria. The side effects include: blurry vision (especially at near) and light sensitivity for at least 4-6 hours. At Viewpoint we recommend a dilation for first time patients, individuals with health conditions like: diabetes, high blood pressure etc, if it has been more than 2 years since the last dilation, or to determine causes of vision changes or loss of vision. If you would like to be dilated, but would need it performed on a separate visit please let the doctor know. Would you like to be dilated today? [ ] Yes [ ] No

How did you hear about us? _____

Viewpoint Eyecare Policies

- Copays must be collected at the time of service. Prescriptions will be held until balance is paid in full.
- Eyeglasses will not be processed until balance is paid in full.
- Contact lens orders will not be processed until balance is paid in full.
- Viewpoint Eyecare does not provide personal financing; however, Viewpoint Eyecare does work with Carecredit as a way for patients/customers to pay for products and/or services. Ask an associate for details.
- Adjustments on frames: see Patient own frame (POF) Waiver
- This list is not inclusive

Contact lens (CL) fitting: If possible a CL prescription will be given the day of the exam if the fit and vision are acceptable to patient and/or doctor. Sometimes a follow up visit is necessary in order to complete the fit of CL. Sometimes, in the case of more difficult fits more time is needed. Due to the extended time, fitting charges may be higher for certain CL like: first time CL wearers, astigmatism, multi-focal, monovision, keratoconus etc. Every fit charge will include, when possible, trials of your prescription to determine overall satisfaction. A refit may be performed within 60 days at no charge (some exclusions apply).

Contact fitting pricing* (Initial)

Spherical (soft): $50	Multifocal/Monovision (soft): $75	RGP Spherical: $75
Toric (soft): $75	1st Time Fit (soft/RGP): +$10	RGP Toric: $100

*Every time a contact lens prescription is updated a fee will be assessed.
Pricing of contact lens fittings will vary depending on insurance coverage, difficulty of fitting and changes in CL parameters. Some exclusions apply. Specialty Contact: Determined at time of exam due to complexity

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgement of Notice of Privacy Practices (NPP)

[ ] Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
[ ] No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
[ ] The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to above all terms _____ Date _____