DWIGHT D BOYD, O.D. JENNIFER MARSHALL, O.D.

Welcome to Eye Q Vision Care

PERSONAL INFORMATION

LEGAL NAME:____ SEX: M / F
LAST FIRST MIDDLE

MAILING ADDRESS: ____
STREET CITY STATE ZIP

PHYSICAL ADDRESS: ____
STREET CITY STATE ZIP

BIRTHDATE: __________________________ AGE: _________________ MARITAL STATUS: _____________________

HOME PHONE (______) _________________ BUSINESS / DAYTIME PHONE (_____) _______________ EXT.________________

OCCUPATION: ________________________________ EMPLOYER: _____________________ SSN ________________________

SPOUSE NAME: ____________________________________ SPOUSE EMPLOYER: ______________________________________

SPOUSE WORK PHONE: (_____) _______________ EXT._______________ OTHER PHONE: (_____) _____________________

EMERGENCY CONTACT: ____ CONTACT NUMBER: (_____) __________________

STATE ANY HOBBIES OR INTERESTS: ____

E-MAIL ADDRESS: ____

DO YOU CURRENTLY WEAR GLASSES? YES □ NO □

PLEASE **CIRCLE** WHAT TYPE OF LENSES: SINGLE VISION, BIFOCALS, PROGRESSIVE, TRIFOCALS, OR READERS.

DO YOU CURRENTLY WEAR CONTACTS? YES □ NO □ IF YES, WHAT TYPE? ____

MAIN VISUAL COMPLAINT: ____

NAME OF PREVIOUS OPTOMETRIST: ____

DATE OF LAST COMPREHENSIVE EXAM: ___________________________________

REFFERED TO US BY:

DWIGHT D BOYD, O.D. JENNIFER MARSHALL, O.D.

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MEDICAL HISTORY

CHECK IF YOU OR ANY OF YOUR BLOOD RELATIVES CURRENTLY HAVE OR HAVE HAD THE FOLLOWING: (**IF SO, STATE WHOM**)

CATARACTS ______________ GLAUCOMA _____________ HIGH BLOOD PRESSURE_____________ DIABETES_______________

CANCER ____________ GASTROINTESTINAL ____________ HEART_____________ THYROID __________KIDNEY____________

MACULAR DEGENERATION ________________ RETINAL DETACHMENT _________________CHOLESTORAL_______________

EAR/NOSE/THROAT__________________RESPORITORY_____________ BLOOD/LYMPH____________STROKE_______________

LUPUS ______________ SHINGLES________________ PARKINSONS __________________ TUBERCULOSIS __________________

AIDS/HIV YES ☐ NO ☐ HEPITITIS YES ☐ NO ☐

ANY RECENT TRAUMA? ____

CHECK IF YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING: (IF SO PLEASE EXPLAIN.)

ALLERGIES	_______________	DISCHARGE	______________	EYE DISEASE	______________
DIABETES	_______________	DRUG SENSITIVITY	______________	EYE SURGERY	______________
SINUSITIS	_______________	DIZZINESS	______________	EYE INJURY	______________
MIGRAINES	_______________	EPILEPSY	______________	GLAUCOMA	______________
RED EYES	_______________	DOUBLE VISION	______________	TUNNEL VISION	______________
DRY EYES	_______________	HEART PROBLEMS	______________	VISION LOSS	______________
WATERING	_______________	LIGHT SENSITIVITY	______________	NIGHT VISION	______________
BURNING	_______________	HALO VISION	______________	TIRED EYES	______________
BLURRING	_______________	ACHING EYES	______________	FLASHING	______________
ITCHING	_______________	HEADACHES	______________	GRITTINESS	______________
FLOATERS	_______________	PULL OR DRAW	______________	TWITCHING	______________

DO YOU SMOKE? YES ☐ NO ☐ IF SO, HOW MUCH? _________________________________

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ IF SO, HOW MUCH? ________________________

DO YOU USE OTHER SUBSTANCES? YES ☐ NO ☐

ARE YOU PREGNANT? YES ☐ NO ☐

DO YOU TAKE ANY MEDICATIONS OR NUTRITIONAL SUPPLEMENTS? YES ☐ NO ☐ PLEASE LIST NAMES AND DOSAGES:
____

PLEASE LIST ANY SURGERIES AND DATE: ____

DO YOU HAVE ANY KNOWN ALLERGIC REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES? IF YES PLEASE LIST:
____

ARE YOU ALLERGIC TO LATEX? YES ☐ NO ☐

ARE YOU INTERESTED IN LASER VISION CORRECTION? YES ☐ NO ☐

PLEASE SIGN BELOW THAT YOU HAVE REVIEWED ALL INFORMATION ABOVE AND IT IS CORRECT TO THE BEST OF YOUR KNOWLEDGE.

PATIENT NAME (PLEASE PRINT): ______________________________ DATE: _________________________

SIGNATURE: ____ DATE: _________________________

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INSURANCE INFORMATION

MAJOR MEDICAL PRIMARY

INSURANCE COMPANY: ____

MEMBER ID # ____

GROUP NAME/NUMBER: ____

MAJOR MEDICAL SECONDARY

INSURANCE COMPANY: ____

MEMBER ID # ____

GROUP NAME/NUMBER: ____

DO YOU HAVE ROUTINE VISION COVERAGE? YES □ NO □ IF YES CONTINUE BELOW:

VISION INSURANCE

INSURANCE COMPANY: ____

MEMBER ID # ____

GROUP NAME/NUMBER: ____

INFORMATION ON PERSON THE INSURANCE IS UNDER AND/OR RESPONSIBLE PARTY

LEGAL NAME: ____RELATIONSHIP TO PATIENT: ______________________________

MAILING ADDRESS: ____
STREET CITY STATE ZIP

PHYSICAL ADDRESS: ____
STREET CITY STATE ZIP

HOME PHONE (______) __________________ BUSINESS / DAYTIME PHONE (_____) ________________ EXT.________________

EMPLOYER: ______________________________ WORK PHONE: (_____) _______________________ EXT. ____________________

SSN: ____________________ BIRTHDATE: ____________________ MARITAL STATUS: ____________________

I CERTIFY THIS INFORMATION IS TRUE AND/OR PERMISSION TO BILL INSURANCE

I hereby authorize release of medical information necessary to report a claim to my plan. I assign benefits otherwise payable to the insured, to the physician indicated on the claim. I understand **I am financially responsible for benefits not covered by my insurance plan**. A copy of this signature is valid as the original.

____

Signature of patient or authorized person. Date

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PLEASE REVIEW AND SIGN
OUR CONTACT LENS EXAMINATION, INSURANCE AND FINANCIAL POLICES!

CONTACT LENS EXAMINATION POLICY

AS IS CUSTOMARY IN OUR INDUSTRY, CONTACT LENS EVALUATIONS ARE NOT A PART OF OUR COMPREHENSIVE EYE EXAMS; AND SINCE THEY REQUIRE ADDITIONAL EVALUATIONS, THEY ARE BILLED SEPARATELY FROM THE EYE EXAM. **CONTACT LENS SERVICES ARE NON-REFUNDABLE AND SOME INSURANCE PLANS WILL NOT COVER.** CONTACT LENSES MAY BE EXCHANGED IN **CASE OF PRESCRIPTION CHANGE, PROVIDED THAT SUCH CHANGE IS MADE WITHIN SIX MONTHS OF THE EXAM AND THE BOXES ARE UNOPENED AND IN GOOD CONDITION**. A 20% RESTOCKING FEE APPLIES. WE RESERVE THE RIGHT TO DENY ANY EXCHANGE REQUEST.

SIGNATURE: ____ DATE:______/______/______

INSURANCE AND FINANCIAL POLICIES

1. By submitting insurance information, you authorize Eye Q Vision Care to submit a billing claim for the materials and services received in our office on your behalf; and agree to pay any and all co-payments required at the time the services are rendered, unless previous arrangements have been made with this office. Regardless of what we may quote you in this office regarding coverage and allowances based on the available information at the moment of said quote, the insurance company will make the final determination of your actual coverage and benefits. You will be responsible for payment of any and all amounts not paid by your insurance.
2. A 50% deposit on all materials (glasses and / or contact lenses) is required at the time of purchase.
3. If you miss your appointment and / or fail to cancel or re-schedule your appointment with this office **with in 24 hours**, you may be assessed a $25.00 **No-Show Fee**.
4. You will be charged a $30.00 fee, or the maximum allowed by law (whichever is higher) for every check returned to us from your bank due to non-sufficient funds. By paying by check you agree to this fee.
5. We reserve the right to assess a **CANCELLATION FEE** for all services, eyewear and contact lenses in case of a cancellation for a reason that is not in accordance with the best practices in optometric care. This fee will be assessed on a case by case basis, but in no case will it be under $50.00.
6. All products purchased in our office need to be picked up within 45 days. After the 45 days we assume no responsibility for any products left in our office, and no monies will be refunded after this time.
7. This office collects an **OPTIONAL** $15.00 Administrative Services Fee from each patient every calendar year. This fee is intended to cover the cost of the administrative services that are not covered by insurance. You are not required to pay this fee; however, if you choose not to pay this fee you will be charged for said services at the prevailing rate at the time of the request. Some of this services are:
   A. Completion of all forms: ($25.00 per form.)
      1. School Forms.
      2. Life Insurance Forms.
      3. Foreign Travel Forms.
      4. Camp and/or Sports related Forms.
      5. Any other miscellaneous administrative forms requested by you or by third parties.
   B. Patient requested reports (additional claims, statements payment histories, etc.) $15.00 per request.
   C. Copying of patient records ($25.00 per request).
   D. Other administrative services which are not covered by insurance (Fee will be determined at the time of the request).

_____ I hereby certify that I have read and understood all the preceding policies and that I am in agreement with them. I also certify that it is my decision to **decline** to pay the Administrative Services Fee described in item # 7.

_____ I hereby certify that I have read and understood all the preceding policies and that I am in agreement with them. I also certify that it is my decision to **pay** the Administrative Services Fee described in item # 7.

SIGNATURE: ____ DATE: ______ / ______ / ______

PRINT NAME: ____ DOB : ______ / ______ / ______