EYE ASSOCIATES OF ORANGE COUNTY
An NVISION® Eye Center

Patient Information Form

Mission Viejo +1(949)364-6688
Santa Ana +1(714)557-5777
www.NVISIONCenters.com

Last Name: _____ **First Name:** _____ **M.I.** _____

DOB: _____ **Age:** _____ **SSN:** _____ **Sex:** ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Address: _____

City: _____ **State:** _____ **ZIP:** _____

*** Phone Numbers:** Home ☐: _____ Work ☐: _____ Cell ☐: _____

** Check box next to phone number(s) where we may leave a message*

Email Address: _____

Employer Name: _____ **Occupation:** _____

How were you referred to NVISION Eye Centers?

☐ Doctor Referral: ☐ Family/Friend/Past Patient - Did they have refractive surgery with us? ☐ Yes ☐ No

_____ _____

** First & Last Name* ** Name & Relationship*

☐ Internet ☐ Drive-by ☐ Benefits Provider ☐ Other:

☐ Health / Workplace Event ☐ Newspaper / Magazine / Advertisement ☐ Radio _____

Which of the following above influenced you the most to schedule an appointment with us? _____

Primary Physician (Full Name): _____ **Phone:** _____ **City:** _____

Optometrist (Full Name): _____ **Office** (Name): _____ **City:** _____

Has your optometrist discussed Laser Vision Correction with you? ☐ Yes ☐ No

Did they refer you to NVISION? ☐ Yes - Which surgeon were you referred to? _____

☐ No - Who were you referred to? _____

Pharmacy: _____ **Phone:** _____ **City:** _____

Primary Insurance: Insurance Co. Name: _____ **ID#:** _____ **Group#:** _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Secondary Insurance: Insurance Co. Name: _____ **ID#:** _____ **Group#:** _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Vision Insurance: Insurance Co. Name: _____ **ID#:** _____ **Group#:** _____

SubscriberName (if not self): _____ Subscriber's Date of Birth (if not self): _____

Emergency Contact Information / Designated Individuals Release:

NVISION Eye Centers may release to, or discuss my personal health information (PHI) (except regarding treatment ☐, payment ☐, and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that NVISION will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing. **Appointment Reminder Release:** ☐ I authorize NVISION may release my name, treatment date, and contact information to a local partnering Optometrist who may prompt me with annual appointment reminder to facilitate follow up care.

Name: _____ **Relationship:** _____ **Ph#:** _____

Name: _____ **Relationship:** _____ **Ph#:** _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for NVISION. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The notice of Privacy is available on our website at www.nvisioncenters.com and in our office. You may request a copy of the NNP.

_____ _____

Sianature ofpatient (if over 18) or patient's parent or legal guardian *Date*

_____ _____

If signed by parent or legal guardian, print name *Relationship*

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Medical History

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Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Glasses / Contact Lenses (Please check appropriate boxes below)

Do you currently wear glasses? ☐ No ☐ Yes If yes, how old are your glasses? _____ Type? _____
Do you currently wear contact lenses? ☐ No ☐ Yes If yes, for how long? _____ Type? _____
Have you ever tried contact lenses? ☐ No ☐ Yes When did you last wear contacts? _____

Allergies (Meds / Latex / Anaesthesia): ☐ No ☐ Yes If yes, which ones: _____

Current Medical Problems: ☐ HTN (High Blood Pressure) ☐ Elevated Lipids (High Cholesterol) ☐ Diabetes Type I ☐ Diabetes Type II
☐ Rheumatoid Arthritis Other: _____

* If applicable, are you currently or possibly pregnant? ☐ No ☐ Yes * If applicable, are you currently breast feeding? ☐ No ☐ Yes

Previous Surgeries: _____

Family History (M-Mother, F-Father, S-Sister, B-Brother, MGM/MGF-MaternalGrandmother/Father, PGM/GF-Paternal Grandmother/Grandfather)

☐ Glaucoma _____ ☐ Diabetes _____ ☐ Cancer _____ ☐ HTN (High Blood Pressure) _____ ☐ Keratoconus _____
☐ Retinal Detachment _____ ☐ Color Blindnes _____ ☐ Macular Degeneration _____ ☐ Other _____

Social History (Please check and / or circle appropriate boxes below)

Do you drive? ☐ No ☐ Yes
Do you drink caffeine? ☐ No ☐ Yes
If Yes, type & amount? _____
Do you drink alcohol? ☐ No ☐ Yes
If Yes, amount & how often? _____
Do you smoke tobacco? ☐ No ☐ Yes If yes, how often? _____
Do you currently vape? ☐ No ☐ Yes If yes, with/without Nicotine? _____
If Yes, have you ever tried to quit? ☐ No ☐ Yes
If Yes, when or how long ago? _____
Have you had passive smoke and/or vaping exposure? ☐ No ☐ Yes

Current Medications: ☐ No ☐ Yes _____
* Include over-the-counter

Review of Systems: Do you currently have any of the following symptoms? (Please check the appropriate boxes below)

Environmental Allergies	☐ No	☐ Yes	Polydipsia (Excessive Thirst)	☐ No	☐ Yes	Rash	☐ No	☐ Yes
Food Allergies	☐ No	☐ Yes	Polyphagia (Excessive Hunger)	☐ No	☐ Yes	Arthralgia (Joint Pain)	☐ No	☐ Yes
Chest Pressure	☐ No	☐ Yes	Hearing Loss	☐ No	☐ Yes	Joint Swelling	☐ No	☐ Yes
Chest Discomfort	☐ No	☐ Yes	Constipation	☐ No	☐ Yes	Muscle Weakness	☐ No	☐ Yes
Irregular Heartbeat	☐ No	☐ Yes	Diarrhea	☐ No	☐ Yes	Dizziness	☐ No	☐ Yes
Heart Palpitations	☐ No	☐ Yes	Vomiting	☐ No	☐ Yes	Gait Disturbances	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes	Dysuria (Painful Urination)	☐ No	☐ Yes	Headache	☐ No	☐ Yes
Fever	☐ No	☐ Yes	Hematuria (Blood in Urine)	☐ No	☐ Yes	Emotional changes	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes	Polyuria (Excessive Urination)	☐ No	☐ Yes	Cough	☐ No	☐ Yes
Cold Intolerance	☐ No	☐ Yes	Bruising	☐ No	☐ Yes	Wheezing	☐ No	☐ Yes
Heat Intolerance	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Other: _____		

Eye History: Have you ever had or been told you have: (Please check the appropriate boxes below)

☐ Cataracts	☐ Cataract Surgery	☐ Herpes Infection of the Eye	☐ Foreign Body Sensation
☐ Glaucoma (High Eve Pressure)	☐ Laser Eye Surgery	☐ Recurrent Corneal Erosion	☐ Irritation or Dryness
☐ Macular Degeneration	☐ Pterygium Surgery	☐ Blurred or Double Vision	☐ Excessive Tearing or Watering
☐ Diabetic Retinopathy	☐ Corneal Surgery	☐ Glare/ Light Sensitivity	☐ Mucous Discharge
☐ Flashes or Floaters	☐ Eyelid Surgery	☐ Distorted Vision / Halos	☐ Redness
☐ Retinal Tear/Detachment	☐ Eye Injury	☐ Loss of Vision	☐ Drooping Eyelids
☐ Keratinous	☐ Amblyopia (Crossed/Lazy Eye)	☐ Eye Pain or Soreness	☐ Other: _____

☐ **I understand that dilating eye drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until Iam certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.**

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

_____ _____
Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____ _____
If signed by parent or legal guardian, print name *Relationship*

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ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

Patient Name: _____ **Date of Birth:** _____

By signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bil of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

_____ _____

Signature of patient *Signature of patient*

Are you completing this form for someone else?

☐ Check here if you are signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you are acting on that person's behalf (for example, power of attorney)

_____ _____

Printed name of patient's personal representative *Date*

_____ _____

Signature of patient's personal representative *Relationship*

References Available on the Internet:
www.hospitalconnect.com/aha/about/pbillofriahts.html
www.isrs.org

Other References:
Internal Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Pre-operative and Post-operative Care, 2001 available form www.isrs.org

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the:

Medical Board of California www.mbc.ca.gov
Oregon Medical Board www.oregon.gov/OMB
Washington Medical Commission https://wmc.wa.gov/
Nevada State Board of Medical Examiners www.medboard.nv.gov
Arizona Medical Board www.azmd.gov

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PAYMENT POLICY

Name: _____ **Date of Birth:** _____

BASIC POLICY:

Payment for service is due in full at the time service is provided in our office.

PATIENTS WITH INSURANCE:

LASIK / REFRACTIVE SURGERY IS NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS

Some treatments are billable to insurance, while others are not. VISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your VISION provider is not contracted with your carrier, payment is due in full at the time of service. fI we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and VISION will supply you with the necessary information to do so. VISION does not guarantee that your insurance provider will reimburse for services rendered. VISION is not responsible for denied insurance claims.

For VISION Eye Institute patients, we wil bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anaesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services wil be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

NON -COVERED SERVICES:

Any care not paid for by your existing insurance coverage wil require payment in full at the time services are provided or upon notice of insurance claim denial.

ASSIGNMENTS OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand Iam financially responsible to VISION for the charges incurred.

Have you met yourdeductiblef o r the calendar year?	☐ Yes	☐ No	☐ Not Sure
Are you currently employed?	☐ Yes	☐ No	
Are your injuries accident related?	☐ Yes	☐ No	
Did you sustain an injury at work?	☐ Yes	☐ No	
Have you ever served in the military?	☐ Yes	☐ No	
Are you covered under an employer or union policy?	☐ Yes	☐ No	
Is your spouse or other family member employed?	☐ Yes	☐ No	
Do you have a secondary insurance policy?	☐ Yes	☐ No	
Are you covered under any other healthcare plan?	☐ Yes	☐ No	

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

_____ _____

Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____ _____

If signed by parent or legal guardian, print name *Relationship*