HEART OF AMERICA EYE CARE, P.A.

PLEASE COMPLETE THIS FORM. IT WILL BECOME PART OF YOUR PERMANENT RECORD

PATIENT INFORMATION

Patient's Name: Last		First	Middle	Maiden	
Address: Street	Apt	City	State	Zip Code	
Date of Birth	**Social Security #**	**Marital Status** S ☐ M ☐ W ☐ D ☐	**Sex:** M ☐ F ☐	**Age:**	
Home Phone:	**Cell Phone:**	**Email Address: ***			
Patient's Employer:	**Occupation:**	**Work Phone:**	**Ext:**		
Employer's Address: Street	City	State	Zip Code		
Spouse/Parent/Guardian (Circle One)	**Social Security #**	**Date of Birth:**	**Employer:**		
Spouse/Parent/Guardian **Employer's Address:**	City	State	Zip Code	**Work Phone:**	
Emergency Contact (outside the home)	**Relationship to Patient**	**Home Phone:**	**Work Phone:**		
Family Physician:	**Address:**	**Phone #:**			
Which pharmacy do you prefer to use?	**Pharmacy Address**				

May we speak with your ☐ Spouse ☐ Parent ☐ Emergency Contact ☐ Anyone ☐ Guardian ☐ Adult Children **about financial statements, test results or other services provided by our office regarding your medical treatment?**

Designated Representative: _____ ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE Company Name	**Policy Holder:**	Policy Holder's Date of Birth:	Relation:
ID or Social Security #	**Group Number:**	Policy Holder's Employer:	
SECONDARY INSURANCE Company Name	**Policy Holder:**	Policy Holder's Date of Birth:	Relation:
ID or Social Security #	**Group Number:**	Policy Holder's Employer:	
VISION PLAN Plan Name	**ID Number:**	**Is prior Authorization required?** Yes ☐ No ☐	
What is the reason for your visit today?			
Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Declined			
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined			
Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other			

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

AUTHORIZATION: I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Heart of America, P.A. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/Other Insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment.

* We may use your Email address to send you information about our practice and specials. However, we will not reveal your Email address to any other person or organization.

☐ I acknowledge receipt of notice of privacy practices
☐ I authorize Heart of America Eye Care to view my prescription from external sources.
☐ I acknowledge that I have read and understand the office polices.

Print Name: _____

Signature _____ **Date** _____

HEART OF AMERICA EYE CARE

Medical History

Name_____ Birth date_____ Today's date_____

Why are you here today?_____

Circle "S" if <u>you</u> have the condition or "F" if a family member has the condition:

		EYE			MUSCULOSKELETAL	S	F	Ulcerative colitis
S	F	Cataracts	S	F	Arthritis	S	F	Abdominal pain
S	F	Glaucoma	S	F	Joint pain			URINARY
S	F	Dry eyes	S	F	Muscle aches	S	F	Enlarged prostate
S	F	Macular degeneration	S	F	Low back pain	S	F	Blood in urine
S	F	Retinal tear/detachment				S	F	Excessive urination
S	F	Fuch's Dystrophy			IMMUNOLOGIC	S	F	Pain w/ urination
S	F	Lazy eye/strabismus	S	F	Rheumatoid arthritis			
S	F	Prior LASIK/PRK/RK	S	F	Sjogren's syndrome			NEUROLOGIC
			S	F	Lupus	S	F	Depression
		HEART	S	F	Sarcoidosis	S	F	Anxiety
S	F	High blood pressure	S	F	Juvenile rheumatoid arthritis	S	F	Headaches
S	F	Coronary artery disease	S	F	Ankylosing spondylitis	S	F	Migraines
S	F	Congestive heart failure	S	F	HLA-B27	S	F	Numbness
S	F	Irregular heart beat	S	F	Myasthenia gravis	S	F	Weakness
S	F	Chest pain				S	F	Alzheimer's disease
S	F	Vascular problems			EAR, NOSE, THROAT	S	F	Memory loss
			S	F	Seasonal allergies			
		RESPIRATORY	S	F	Hearing loss			GENERAL HEALTH
S	F	Asthma	S	F	Sinus problems	S	F	Fatigue
S	F	COPD/emphysema	S	F	Sore throat	S	F	Unexpected weight loss/gain
S	F	Sleep apnea				S	F	Hepatitis
S	F	Shortness of breath			SKIN DISORDERS	S	F	HIV/AIDS
S	F	Wheezing	S	F	Rosacea			
S	F	Coughing	S	F	Eczema			CANCER
			S	F	Excessive dry skin	S	F	Melanoma
		ENDOCRINE				S	F	Skin cancer
S	F	High cholesterol			GASTROINTESTINAL	S	F	_____
S	F	Type I diabetes since _____	S	F	Acid reflux	S	F	_____
S	F	Type 2 diabetes since _____	S	F	Ulcers			
S	F	Thyroid disorder	S	F	Crohn's disease			
S	F	Grave's disease						

Other conditions not listed above_____

Eye medications/drops_____

Other medications (or attach list)_____

_____

Allergies (medications, food, etc)_____

Eye surgeries_____

Major surgeries (with date); minor surgeries in last 5 years_____

_____

Do you smoke? Never Current Former _____ packs/day for _____ years (quit _____ yrs ago)

Do you drink alcohol? No Rare Yes _____ drinks per *(circle):* day week month

HEART OF AMERICA EYE CARE, P.A.

Bradley Kwapiszeski, MD · Jodianne Carter, MD · Caroline Chang, MD
Brenda Edwards, OD · Laura Brammer, OD · Stephanie Erker, OD

Due to many changes with insurance plans and from healthcare reform, NOT all insurance plans cover a routine eye/vision exam. It is the responsibility of the insured to know the EXACT benefits of their insurance plan. You must inform us whether your visit will be a medical exam or a routine vision exam.

NO CHANGES CAN BE MADE AFTER THE EXAM IS COMPLETED.

☐ **MEDICAL** (i.e. diabetes, cataracts, glaucoma, red eye, floaters)

☐ **ROUTINE VISION** (i.e. glasses, contact lens evaluation)

DO YOU HAVE A VISION PLAN? VSP Eyemed Spectera VCP
(circle)

Primary Member_____

Birth Date_____ SSN_____

Please provide ALL of your insurance cards at your appointment.
We will file the insurance you designate and cannot re-file after your date of service.

_____ _____

Signature Date