Neighborhood Vision Center
Kent Kneip, O.D., PLLC

Welcome! Please fill out completely

PATIENT REGISTRATION:

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-Mail: _____

Sex: □ Male □ Female How would you prefer to be contacted? □ Home □ Work □ Cell □ E-Mail

Patient's Social Security #: _____ If student, grade: _____ School: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse or Emergency contact name: _____

Primary Care Physician: _____ Last Medical Exam: _____

If the patient is a child, Parent / Guardian name:_____ Last eye exam: _____

For new patients: How did you hear about us?

□ Friend / Acquaintance □ Insurance Plan □ Driving by □ Phone book □ Internet □ Other _____

If referred by a friend or family member, who: _____

VISION INSURANCE:

Who is the primary insured person on the vision insurance plan?: □ Self (the patient) □ Spouse of the patient □ Parent of the patient

Insured's name (if other than the patient): _____ Insured's Date of Birth (if other than the patient): _____
Insurance company: _____ Insured's employer: _____
Insurance company's address: _____ Insured's Soc. Sec. # (if other than patient): _____
Insured's member ID #: _____ Insured's group #: _____

PRIMARY MEDICAL INSURANCE:

Who is the primary insured person on the medical insurance plan?: □ Self (the patient) □ Spouse of the patient □ Parent of the patient
Insured's name (if other than the patient): _____ Insured's Date of Birth (if other than the patient): _____
Insurance company: _____ Insured's employer: _____
Insurance company's address: _____ Insured's Soc. Sec. # (if other than patient): _____
Insured's member ID #: _____ Insured's group #: _____

SECONDARY MEDICAL INSURANCE:

□ If there is also a secondary Medical Insurance, please check here and notify the receptionist

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PERSONAL EYE HISTORY

Chief complaint / Reason(s) for visit: _____

Current problems with your eyes (Check all that apply):

□ Blurred vision	□ Eyestrain or tired eyes	□ Loss of vision or blind spots	□ Floaters or spots in my eyes
□ Flashes	□ Double vision	□ Infection of the eye or lid	□ Mucous discharge
□ Dryness	□ Burning	□ Foreign body sensation	□ Eye pain or soreness
□ Itching	□ Redness	□ Sandy or gritty feeling	□ Glare or light sensitivity
□ Tearing			□ ***Check here if none of these apply***

Past or present eye history (Check all that apply to your eyes):

□ Cataracts	□ Macular degeneration	□ Drooping eyelid(s)	□ Prominent eyes	□ Dry eyes
□ Glaucoma	□ History of eye exercises	□ Eye patching	□ Lazy eye	□ Crossed or turned eye
□ Blindness	□ Previous eye infections	□ Styes or chalazions	□ Keratoconus	□ Artificial eye
□ Bell's Palsy	□ Retinal Detachment	□ Diabetic retinopathy	□ ***Check here if none of these apply***	

Please list any eye drops you are using (include OTC drops): _____

Have you ever had any eye injuries? □ Yes □ No If yes, please explain: _____

Have you ever had any eye surgeries? □ Yes □ No If yes, for: _____

Do you do a lot of detailed near work, or work a lot at a computer? □ Yes □ No

Hobbies: _____ Sports: _____ Leisure activities: _____

Do you wear glasses? □ Yes □ No □ Never Do you wear contact lenses? □ Yes □ No □ Never

FAMILY MEDICAL AND EYE HISTORY

This applies to <u>family</u> <u>members</u>. Please check yes or no for each condition. If yes, list who it applies to (F father M mother B brother S sister):

Family Medical History:				**Family Eye History:**			
Cancer:	□ Yes	□ No	_____	Glaucoma	□ Yes	□ No	_____
Diabetes:	□ Yes	□ No	_____	Keratoconus:	□ Yes	□ No	_____
Heart Disease:	□ Yes	□ No	_____	Macular Degeneration:	□ Yes	□ No	_____
High Blood Pressure:	□ Yes	□ No	_____	Retinitis Pigmentosa:	□ Yes	□ No	_____

How many siblings (brothers and sisters)? _____

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PERSONAL MEDICAL HISTORY

Do you have any allergies to any medications? □ Yes □ No If yes, list: _____

Do you smoke/use tobacco currently? □ Yes □ No If yes, how often? _____

Do you drink alcohol? □ Yes □ No If yes, how often? _____

List any major injuries, surgeries and hospitalizations you have had: _____

Are you pregnant? □ Yes □ No If pregnant: _____ Weeks / Months Are you nursing? □ Yes □ No

Are you taking any **prescription medications**? □ Yes □ No

Are you taking any **over-the counter medications**? □ Yes □ No

If yes, please check the medical condition and list the medications below:

Disease / Condition	Medications	Disease / Condition	Medications□□
□ Allergies (environmental)	_____	□ Anemia □ Bleeding problems	_____
□ High blood pressure	_____	□ Lupus	_____
□ Heart trouble/problems	_____	□ Fibromyalgia	_____
□ Cholesterol problems	_____	□ Sjogren's	_____
□ Stroke	_____	□ Acne □ Eczema □ Psoriasis	_____
□ Vascular disease	_____	□ Warts □ Vitiligo □ Sarcoid lesions	_____
□ Recent weight loss □ gain	_____	□ Rosacea	_____
□ Fever	_____	□ Shingles	_____
□ Fainting □ Dizziness	_____	□ Arthritis (Osteoarthritis)	_____
□ Diabetes, Type □ 1 □ 2 □ Diet	_____	□ Rheumatoid arthritis	_____
□ Hypoglycemia	_____	□ Injury to joint or spine	_____
□ Thyroid problems	_____	□ Muscle pain	_____
□ Graves disease	_____	□ Headaches (migraines)	_____
□ Pituitary disorder	_____	□ Headaches (non-migraine)	_____
□ Gout	_____	□ Multiple sclerosis	_____
□ Hormone imbalance	_____	□ Parkinson's disease	_____
□ Menopause	_____	□ Alzheimer's disease	_____
□ Diarrhea □ Constipation	_____	□ Siezures	_____
□ Acid reflux	_____	□ Cerebral palsy	_____
□ Ulcer □ Stomach problems	_____	□ ADD □ ADHD	_____
□ Colitis □ Crohn's	_____	□ Depression	_____
□ Hepatitis □ Liver problems	_____	□ Anxiety	_____
□ Bladder infections/problems	_____	□ Insomnia	_____
□ AIDS □ HIV positive	_____	□ Other psychiatric problems	_____
□ Syphilis □ Gonorrhea □ Herpes	_____	□ Asthma	_____
□ Kidney problems/kidney stones	_____	□ Bronchitis	_____
□ Birth control	_____	□ Emphysema □ COPD	_____
□ Sinus problems/hay fever	_____	□ Cystic fibrosis	_____
□ Chronic cough	_____	□ Sleep apnea	_____
□ Hearing loss	_____	**Other Symptoms or Conditions**	
□ Ear infection □ Vertigo	_____	□ _____	_____
□ Cancer, type_____	_____	□ _____	_____

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PUPIL DILATION and OPTOMAP IMAGING

As part of a comprehensive eye exam our doctor looks at the retina, which is the tissue that line the inside of the back of the eye. Viewing the retina is necessary to detect and prevent eye diseases that could lead to vision loss or blindness. Many diseases of the eye have no early symptoms and may not be detected without a thorough retinal exam. The view our doctor gets of your retina depends on the size of the **pupil**, which is the opening that regulates the amount of light entering the eye. When light is shined into the eye to evaluate the retina, the pupil normally constricts. This limits the view our doctor gets of your retina. So looking at the retina through an **undilated pupil** is a limited view.

A much more comprehensive view is obtained when the **pupil is dilated**. This is done with medical eye drops. If you choose dilating drops the side effects will include sensitivity to light, blurred near vision and occasionally blurred distance vision, depending on your prescription. These side effects will usually last for about 4 to 8 hours depending on the color of your eye and the strength of the eye drop. The dilated retinal exam is at no extra charge. Neighborhood Vision Center provides complimentary sun protection with a dilated exam.

Another comprehensive view of the retina is obtained with the retinal Optomap. The Optomap is painless and requires no drops and does not affect your vision. This is similar to taking a photograph, but it gives a much broader view of the retina than we get with a traditional camera. It gives us both 2 and 3-dimensional images of your eye. The image of your retina is kept on file for comparison at subsequent visits. The Retinal Optomap is not usually covered by insurance and has a charge of **$ 29.**

A dilated exam and/or an Optomap is strongly recommended by our doctors for <u>all</u> patients yearly.

Pupil dilation: □ Yes, I want pupil dilation today □ No, I do not want pupil dilation today

Optomap: □ Yes, I want the Optomap retinal exam today □ No, I do not want the Optomap retinal exam today

Patient / Guardian signature _____ Date _____

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Consent to Treatment: I hereby consent to any routine procedures, medical treatment or facility services rendered under the general and specific instructions from the attending Optometrist.

Release of Information: I hereby authorize any person/institution rendering care to furnish all information concerning this claim, as noted in the HIPAA Notice of Privacy Practices. Neighborhood Vision Center may disclose all or any part of my medical record and / or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under direct contract to Neighborhood Vision Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Neighborhood Vision Center may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Financial Acknowledgement: I authorize payment for my vision and medical benefits directly to the Neighborhood Vision Center. I agree that if my employer, insurance carrier or plan sponsor (hereafter referred to as "plan") denies payment of all or any portion of my claim, I will be financially responsible for payment of all outstanding charges, subject to the agreement between the Neighborhood Vision Center and my plan.

Assignment of Benefits: I authorize the use of the signature below for all insurance submissions from the Neighborhood Vision Center and its doctors on my behalf.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Kent Kneip, OD, PLLC, dba Neighborhood Vision Center, for services furnished me by Neighborhood Vision Center. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claims forms, my signature authorizes releasing the information to the insurer or agency shown. Neighborhood Vision Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Professional Fees: Professional fees are due upon completion of examination. Professional fees are non-refundable.

Insufficient Fund Policy: I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payments thereafter, and I will be obligated to pay a returned check fee of $25.00.

HIPAA Notice of Privacy Practices: I understand that I have been given the opportunity to view the Privacy Policy. I understand that if I desire a copy, one shall be given to me by the office staff. The policy is located on the table in the waiting area of the lobby. I understand that I may contact the HIPAA compliance officer at the Neighborhood Vision Center with any questions.

Beneficiary Signature or Authorized Party _____ **Date** _____

For staff use only: Reviewed registration info., med. hx , testing auth., & info. above: Tech Init. _____ Dr. Init. _____ Date _____