revolutionEYES

WELCOME TO OUR OFFICE

PATIENT HISTORY FORM **DATE:**

First, Last, MI Name	**Preferred Name**	**Date of Birth**
Occupation		

REASON FOR VISIT (Circle appropriate response.)

Do you feel your vision needs improvement? **YES** **NO**
Describe as needed:

How do your eyes feel? **Acceptable** **Needs Improvement**
Describe as needed:

How do your eyes look? **Acceptable** **Needs Improvement**
Describe as needed:

How many hours are you on an electronic device? (ie. cell phone, computer, laptop, etc.)

HOBBIES

EYE HISTORY

Currently Wear Glasses **YES** **NO**
How old are the glasses?

Currently Wear Contact Lenses **YES** **NO**
Type/brand/prescription:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.
(GP- Grandparent, F-Father, M-Mother, S-Sibling, C-Child)

LASIK or RK	Self	GP	F	M	S	C
LAZY EYE	Self	GP	F	M	S	C
GLAUCOMA	Self	GP	F	M	S	C
CATARACTS	Self	GP	F	M	S	C
RETINAL DEG.	Self	GP	F	M	S	C
MACULAR DEG.	Self	GP	F	M	S	C

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.
(GP- Grandparent, F-Father, M-Mother, S-Sibling, C-Child)

ALLERGIES	Self	GP	F	M	S	C
CANCER	Self	GP	F	M	S	C
DIABETES	Self	GP	F	M	S	C
HEART DISEASE	Self	GP	F	M	S	C
HIGH BLOOD PRESSURE	Self	GP	F	M	S	C
HIGH CHOLESTEROL	Self	GP	F	M	S	C
STROKE	Self	GP	F	M	S	C
THYROID DYSFUNCTION	Self	GP	F	M	S	C

OTHER

Current Medications (prescriptions and over-the-counter)

Medication Drug Allergies

Are you pregnant or nursing?

Do you smoke?
Have you ever smoked?

Do you drink?
If yes, frequency?

PLEASE DESCRIBE ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR HERE.

GENERAL INFORMATION (Please provide ID card.)

First, Last, MI Name	**Preferred Name**
Date of Birth	**Male/Female**

Vision insurance will typically cover a routine evaluation of the eye health and vision, whereby treatment involves a spectacle and/or a contact lens prescription.
Medical insurance coverage applies when there is a medical diagnosis or condition present in the eye (ie. diabetic retinopathy, cataracts, eye infection, etc.) that cannot be treated with a spectacle prescription. Instead, they require treatment with medication and/or other therapies.
I authorize revolutionEYES to file my claim with the appropriate insurance based on the reason and result of my examination.

X INITIAL : _____

INSURANCE POLICY

- Co-payments, co-insurance, deductibles, all previous balances, and non-covered items and services exceeding your annual maximum are due at the time of service.
- If your insurance requires you to have a referral at the time of your visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay in full for the visit.
- The patient is responsible for any amount not covered by insurance. Payment is due within 60 days from time of service.

X INITIAL _____

FINANCIAL POLICY

- There are **NO REFUNDS** on spectacle orders. (At the doctor's discretion, patients who are not satisfied with the vision in their new spectacles may have the prescription adjusted, one time at no cost, within 30 days of the purchase date.)
- There are **NO REFUNDS and NO EXCHANGES** on non-prescription sun wear.
- All purchases must be paid in full before or at the time they are dispensed.
- All spectacle orders require a deposit of at least 50% before the order is placed.
- If the spectacles are not picked up within 30 days of notification, the deposit is non-refundable and the spectacles will be disassembled.

X INITIAL _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and have been given a copy of revolutionEYES' Notice of Privacy Practices.

X SIGN AND DATE: _____

(If patient did not sign) Print Name and relationship to patient: _____