Bauer EYECARE

NEW PATIENT

1. **What is the most important thing you want addressed during this visit?**

2. **Have you ever been diagnosed with any of the following eye conditions?**

Eye Infection	Cataracts	Floaters or Flashes of Light	Diabetic Retinopathy
Allergy	Glaucoma	Retina Defects or Degenerations	Other
Dry Eye	Macular Degeneration		
Iritis or Uveitis			

3. **Are you having any of the following eye concerns?**

Blurry Vision	Poor Night Vision	Total Loss of Vision	Tearing
Eyestrain	Severe Sensitivity to Lights	Redness	Discharge
Headache	Double Vision	Itching	
Bothersome Night Glare	Eye pain	Burning	

4. **Tell us about your current corrective lenses.**

Far/Distance Vision:	Acceptable	May Need Improvement	Blurry
Near/Reading Vision:	Acceptable	May Need Improvement	Blurry
Computer Vision:	Acceptable	May Need Improvement	Blurry

5. **Any injuries or surgeries to your eyes?**

6. **Do you smoke?**

7. **Do you drink?**

8. **What contact lenses do you wear (brand and power)?**

9. **Do you use the computer for extended periods?** **Hours per day?**

10. **What hobbies do you have?**

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11**. How often do you experience any of these symptoms?**

	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Headaches	○	○	○	○	○
Pain in Neck/Shoulders	○	○	○	○	○
Discomfort with Computer	○	○	○	○	○
Tired Eyes	○	○	○	○	○
Dry Eye Sensation	○	○	○	○	○
Light Sensitivity	○	○	○	○	○
Dizziness	○	○	○	○	○

12. **Do you have any of the following health conditions?**

Hypertension	Congestive Heart Failure	Hyperthyroidism	Bipolar
Diabetes	Asthma	Hypothyroidism	PTSD
High Cholesterol	COPD	Depression	ADHD
Cancer		Anxiety	Other_____

13. **What medication do you take?**

14. **Do you have any medication allergies?**

15. **Family Medical History of:** Cancer, Diabetes Type 1 or 2, Hypertension, Hypo/Hyperthyroidism, Cataracts, Glaucoma, Degenerative Disorder of Macula or Other? Please write it down

Mom:

Dad:

Brother:

Sister

Son:

Daughter:

EXPLANATION OF COVERAGE

Estimated out of pocket for patient

Section 1: Coding & Billing Comprehensive Eye Exam

I understand that the exam will be coded as ROUTINE (TO VISION INSURANCE) or MEDICAL (TO MEDICAL INSURANCE) based on the results, diagnosis and suggested treatment of the comprehensive eye exam performed by my doctor.

Routine $ _____

If Medical $ _____

After I will be responsible to pay a copay, coinsurance, or deductible.

Section 2: Refraction Service & Fee:

The refraction determines if I would benefit from a prescription for glasses or contacts. **MEDICAL INSURANCE plans, including Medicare, do not cover this cost.** I understand the cost is $65. Medical and Vision insurance cannot be billed the same day. **Refraction is needed before your Cataract surgery referral and 1 month after your surgery.**

$_____

Section 3: Contact Lens Management & Fee:

I understand that contact lens evaluation is an additional service to a comprehensive eye exam. The cost of the contact lens evaluation is dependent on the type of contact lenses that I am being evaluated for and the time, measurement and trials that go into that lens evaluation. The CL evaluation includes follow ups within 60 days, after that time there will be additional charges. Please read FAQ for contacts. ($85-$150)

$_____

Discount (%)

Allowance

Section 4: Retinal imaging (Optomap + OCT)

We perform retinal imaging on all our patients because it aids in early detection of vision threatening conditions by 80%, providing a more accurate diagnosis and a better understanding of your general health, not just your eyes. Optomap up to $39.

After 40 years of age, risk of certain conditions such as macular degeneration increases and because of this we do an additional test called an OCT. OCT up to $29

Optomap $_____

OCT $_____

Section 5: IPL & other procedures

$_____

Initials_____

PLEASE ASK IF YOU HAVE ANY QUESTIONS

Bauer EYECARE

PATIENT DEMOGRAPHICS: * All fields are required Nickname:_____

Legal first name: _____

Last name: _____

DOB: _____/_____/_____

Cell #: _____

Home #: _____

Address: _____

_____

City: _____

Zip code: _____

Email: _____

VISION INSURANCE:

Primary Holder: _____

DOB of Primary holder: _____

Last 4 SSN of Primary Holder: _____

MEDICAL INSURANCE:

Name of primary insurance: _____

TRICARE SSN of Sponsor or BND_____

Name of supplement or secondary insurance: _____

_____

I understand that I am responsible to provide my correct insurance information before my appointment. If my information is not correct there will be an out-of-pocket charge of $185 and I can request itemized receipts to submit by myself to my insurance for reimbursement. I confirm that I have read, understand, and agree the Notice of Privacy Practice/Terms and conditions and authorize the release of information to insurance companies. I understand that I may be liable for all or portion of the bill.

I authorize to disclose my health information by email or text.

I understand that if my appointment is medical and not routine, I might have a copay, coinsurance, and/or a deductible to pay.

Initials: _____