Medical History Form LV **Patient Name: _____**

Medical History

O not applicable

O diabetes
O hypertension (high blood pressure)
O elevated cholesterol
O anxiety
O depression
O arthritis
O heart disease
O hypothyroidism
O hyperthyroidism
O gastric reflux/ulcer (GERD)
O other
_____
_____
_____
_____

Surgical History

O not applicable

O cardiac cath/stent
O cardiac bypass
O cardiac pacemaker
O cardiac defibrillator
O thyroid removal
O appendix removal
O gallbladder removal
O other_____
_____

Ocular History

O not applicable

O cataract surgery → Which eye? When? → _____
O present cataracts
O glaucoma
O macular degeneration
O other eye conditions
O prior eye surgeries (specify eye and date)
_____
_____

List ALL Medications (including vitamins and supplements)

O no medications
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies

O no known drug allergy
_____
_____
_____
_____

Social History

Smoking
O never O former
O occasional
O daily

Alcohol
O none
O occasional
O daily

Family History
O glaucoma
O macular degeneration
O keratoconus

Review of Systems (CURRENT)

Eyes
O eye pain O tearing
O redness O vision loss
O poor vision

Constitutional
O fevers
O chills
O weight loss

ENT and Mouth
O stuffy nose O cough
O ear ache
O dry mouth

Cardiovascular
O high blood pressure
O rapid heart beat

Respiratory
O congestion
O wheezing
O shortness of breath

Gastrointestinal
O upset stomach
O diarrhea
O constipation

Genitourinary
O burning on urination
O urinary frequency
O incontinence

Musculoskeletal
O joint pain
O stiffness
O arthritis

Integumentary/Skin
O rash
O changing moles

Neurological
O headache
O seizure O stroke
O paralysis

Psychiatric
O anxiety
O depression
O insomnia

Endocrine
O diabetes
O thyroid abnormalities

Hematologic/Lymphatic
O bleeding
O anemia

Allergic/Immunologic
O allergies
O hay fever
O hives

Pregnancy
O Pregnant
O Planning Pregnancy
O Breastfeeding

Patient Registration

Patient's Name: _____"_____"
(First) (MI) (Last) (Nickname)

Gender O Male O Female Birth Date: ___/____/_____ Patient SSN: _____

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

Primary Phone#: _____ Phone Type: □ Cell □ Home □ Work

Secondary Phone#: _____ Phone Type: □ Cell □ Home □ Work

E-mail Address: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Legally Separated □ Decline to Specify

Ethnicity: □ White □ Hispanic/Latino □ African American □ Asian □ Decline to Specify

Patient's Employer: _____ Position:_____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Phone Type: □ Cell □ Home □ Work

Primary Care Physician: _____Referring Physician:_____

Preferred Pharmacy: _____ Phone#:_____
Address or Cross road: _____ City: _____

Primary Insurance Carrier: _____ Member ID: _____
Secondary Insurance Carrier: _____ Member ID: _____

Subscriber of Insurance Name: _____ DOB: ____/____/_____
SSN: _____Relationship to Patient: _____

Notice of Privacy Practices- HIPAA policy information

□ I, (Print Patient Name) _____, have been notified of Dr. Nemi's privacy policies and procedures. I understand a copy of the policies and procedures will be provided to me upon request.

Dilating Eye Drops

□ Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision

will be affected. Because driving may be difficult immediately after an examination, it is best to make arrangements if you are not comfortable driving. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Dr. Nemi and/or such assistants as may be designated to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Cancellation/No Show Policy

- Please call us by 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. For text and e-mail reminders, you may reply to the message to notify us. If prior notification is not given, you will be charged $50.00 for the missed appointment. The fees are the sole responsibility of the patient/guardian. *Patients will be discharged from our services if more than 3 no-show/cancellations occur in a row.*

Billing Medical Insurance

- All examinations are billed to your medical, not vision insurance. We are not in network with any vision plans. The reason for the exam and the doctor's diagnosis dictates how we must bill our patients. Initial visits constitute a complete medical examination of the eyes.
- Payment is due at the time services are rendered. Ultimately you are responsible for any remaining balance that your insurance company denies or deems as a non-covered service. We will provide an estimate from your insurance company as a courtesy. Should there be any additional services rendered or deductibles, co-insurance, copays owed, you may still receive a statement after your visit outlining any remaining responsibility. To ensure that you receive proper coverage, please contact your insurance company.

Refraction Service and Fee- $45.00

- Most major medical plans do not pay for refraction. Refraction is how we determine the best-corrected visual acuity as part of assessing the overall health of the eyes. It provides essential information for the physician during the evaluation, especially new patient examinations, regardless of the nature for the visit.
- Refraction requires specialized equipment and is performed by the doctor or specialty-trained technicians. However, despite its importance, some insurance companies choose not to cover this test. We will collect this fee at the time of your service if we know in advance it is not covered. The fee for this charge is $45.00.

Contact Lens Exam and Fees

- The state of Georgia requires that a contact lens evaluation be done every 12 months to update your contact lens prescription and to maintain the health of the eye. This applies to all patients even though you may have worn contact lenses in the past or even if the prescription does not change. The doctor will check and measure the diameter and curvature of the eye and make sure there is no over wear with the contact lens. Contact lenses, regardless of how well they fit reduce the amount of oxygen to the cornea and can increase your risk of dry eyes, inflammation, and infection. Contact lens evaluation fees are not included as part of your comprehensive exam charge. Our contact lens exam fee is $65.00. There will be an additional insertion and removal training fee of $35.00 for all new contact lens wearers.

I have read and understand the above information. I accept full financial for the cost of refraction and/or contact lens exam in addition to any other eye exam services. I understand that any copay, coinsurance, or deductible I may have are separate from and not included in either the refraction fee, contact lens fitting fee, or other non-covered procedures.

Please note: All accounts delinquent past 60 days from date of service will incur a $35 service charge. Returned checks will incur a charge of $25.00.*

Print Patient Name: _____Patient Signature: _____Date: _____