Patient Registration

Name	DOB
Address	SSN
City State Zip	Marital Status ❑ Single ❑ Married ❑ Divorced
Home Phone	Employment Status ❑ Full Time ❑ Part Time ❑ N/A
Daytime Phone	Employer
Cell Phone	
Email Address	Occupation
How did you find our office today?	**Whom may we thank for referring you to us?**
❑ Insurance List ❑ Doctor ❑ Internet ❑ Billboard	Name
❑ Newspaper ❑ Radio ❑ Mailer ❑ Saw Building	Relationship
❑ Other (explain):	

Privacy Policy & Signature on File

I understand that I am entitled to a copy of this notice upon request. I have reviewed, or been made available a copy of the notice of Privacy Practices regarding HIPAA policies at Kyle Vision PLLC. I understand that my medical records are confidential and that by signing this form I am allowing my information to be released to my insurance company upon request. I hereby authorize payment of health insurance benefits to Kyle Vision PLLC.

Signed: ____

❑ I am a previous patient (name filled above) and there are no changes to the information in the above section this year

Screening Tests

Our goal is to set the standard for comprehensive eye care. We are committed to detecting eye disease ***earlier!***

Visual Field Screening: This new test is helpful in detecting signs of eye disease earlier and is useful in patients diagnosed with forms of vision loss, headaches, diabetes, hypertension and cholesterol. Both central and peripheral vision is evaluated for any loss of sight. Studies have shown this test to be the most accurate early screening test for glaucoma.

Recommended annually on ALL patients over the age of 40.

❑ I agree to the visual field screening ($20)
❑ I decline

MEDICAL HISTORY (REQUIRED ANNUALLY)

Reason for Today's Visit (please check all that apply)	
❑ Blurry vision ❑ Dryness or burning ❑ Headaches ❑ Eye strain ❑ Redness ❑ Burning ❑ Eye pain ❑ Watery eyes ❑ Sudden vision loss ❑ Double vision ❑ Floater/Flashes ❑ Foreign Body ❑ Blurry vision without glasses/contacts	
Last Eye Exam	Previous Eye Doctor
Last Physical Exam	Primary Care Doctor
Current medications taken	
Allergies to an medicines/drugs? ❑ None ***Please list:***	
List all major surgeries & hospitalizations:	
Do you use tobacco products? ❑ No ❑ Yes Type/Amount/How long:	
Do you drink alcohol? ❑ No ❑ Yes Type/Amount/How long:	

General History		
❑ Diabetes	❑ Heart Attack	❑ Acne Rosacea
❑ High Cholesterol	❑ Heart Disease	❑ Lupus
❑ High Blood Pressure	❑ Stroke	❑ Lung Disease
❑ Glaucoma	❑ Head trauma	❑ Asthma
❑ Eye surgery	❑ Migraines	❑ Stomach problems
❑ Retinal or corneal disease	❑ Seizures	❑ Renal Disease
❑ Lazy eye	❑ Hepatitis	❑ Thyroid
❑ HIV	❑ Cancer	❑ Arthritis

Review of Systems (please circle any of the following symptoms or problems ***CURRENTLY*** afflicting you)

Constitutional	Cardiovascular	Endocrine	Gastrointestinal	Neurological	Musculoskeletal
❑ Chills	❑ Chest Pain	❑ Cold Intolerance	❑ Abdominal Pain	❑ Tingling	❑ Joint pain
❑ Weakness	❑ Heart Failure	❑ Excessive Thirst	❑ Diarrhea	❑ Numbness	❑ Low back pain
❑ Fatigue	❑ Heart Murmur	❑ Excessive Hunger	❑ Vomiting	❑ Seizures	❑ Muscle aches
❑ Fever	❑ Palpitations	❑ Heat Intolerance	❑ Nausea	❑ Memory loss	❑ Muscle cramps
Genitourinary	Ear,Nose,Mouth	Blood/Lymphatic	Integumentary	Psychiatric	Respiratory
❑ Discharge	❑ Dry Mouth	❑ Anemia	❑ Rashes	❑ Depression	❑ Coughing
❑ Incontinence	❑ Earaches	❑ Easy Bleeding	❑ Itching	❑ Mood swings	❑ Pneumonia
❑ Infections	❑ Sore Throat	❑ Easy Bruising	❑ Psoriasis	❑ Anxiety	❑ Spitting up blood
❑ Pain	❑ Dizziness	❑ Swollen Glands	❑ Dermatitis	❑ Hallucinations	❑ Wheezing

Family History (includes your parents, grandparents, siblings)	
Diabetes	Glaucoma
High Blood Pressure	Macular Degeneration
Cancer	Retinal Disease
Thyroid Disease	Crossed Eyes

Financial & Insurance Consent

We often have patients that carry both medical insurance & a vision plan. Because we are a medically oriented practice, it is important for you to understand how they differ in the services that they cover. We will always do our best to maximize your benefits to ***your advantage***.

Your ***medical insurance*** allows us to provide a comprehensive eye examination, or office visits as many times as needed throughout the year. Blurry vision, dry eyes, red eyes, eye allergies, cataracts, floaters, retinal problems, diabetes, or anytime a doctor has to write a prescription for medicine are examples of when your medical insurance will apply to your visit.

Your ***vision plan*** provides you with a one time "basic" examination benefit. This assumes healthy eyes that only suffer from problems like nearsightedness, farsightedness, astigmatism or presbyopia. If a medical symptom or sign presents itself during the exam, your vision plan will not cover your visit, however, your medical insurance will. Which insurance gets billed ultimately depends on your final diagnosis. This can only be determined at the completion of your exam.

Vision Exam	Medical Exam
Patient has no complaints.	Complaints may include: Dry eyes, Itchy eyes, Headaches, Blurry vision, Floaters, Red eyes.
The eye is healthy. Only a refractive diagnosis is present.	Presence of medical diagnosis. Examples: All diabetic patients, cataracts, contact lens overwear, glaucoma
No prescriptions for medicine written	If necessary, prescription medicine is written
A refraction is performed (glasses prescription)	A refraction can be performed
Vision plan is billed	Medical insurance is billed

I understand that if a medical diagnosis is present my medical insurance ***will be billed*** and I am responsible for all copays/deductibles today. ______ (initial here)

If I do not present medical coverage at my visit today & my exam becomes medical in nature, I am responsible for a comprehensive exam ***($140)*** ______ (initial here)

If I carry ***both*** routine vision coverage through my medical insurance & also a separate vision plan, I understand my medical insurance will be ***primary*** as it covers a more comprehensive eye exam. ______ (initial here)

Optional: If my medical insurance does not cover all of my charges, I authorize the use of my vision plan to act as a secondary insurance ***(this allows me to pay the least out of pocket)***. ______ (initial here)

I understand this form and I authorize Kyle Vision PLLC to file with either insurance carrier, as determined by my ***final diagnosis***. In the event of an overpayment from an insurance company, the excess amount will be posted as a credit to my account. I am responsible for any amount not covered or paid for by my insurance for services & materials provided today. Full payment is expected within 30 days of such notice from the date the bill was mailed. I am responsible for all accounting, returned check or late fees and collection costs in the event of my non-payment.

________________ (Name)   ________________ (Signature)   ________________ (Date)

Please feel free to ask us any additional questions regarding insurance, **prior** to your examination. Present your insurance cards at the time of service, as we are unable to retroactively file vision or medical claims.

Contact Lens Disclosure

Contact lenses are prescription medical devices that offer a safe alternative to spectacles when cared for properly. They must be evaluated and managed by your doctor annually to ensure comfortable, safe, and healthy wear for years to come. Your doctor will determine the proper replacement interval and wear schedule.

A contact lens exam is different from a "glasses" exam. It is assessed a higher fee than an eye exam based on the evaluation performed by your doctor and is due today. Your annual contact lens evaluation covers the doctor's time and expertise spent to evaluate your eyes health for contact lens wear, and also to measure, design and select the most appropriate lenses it needs (power, diameter, base curve, etc.).

Your evaluation covers all follow-ups necessary to manage problems associated with the *comfort* or *vision* in your lenses ***for up to 30 days***, at no additional charge to assure both the patient & doctor are satisfied. We urge patients to call us immediately if such problems arise. We are always happy to give you a copy of your finalized prescription.

Annual Contact Lens Evaluation Fees*

Spherical ($60)

Astigmatism, extended wearer, complex fit, first time wearer ($90)

Bifocal soft lens, complex fit ($120)

Gas permeable lens wearer (*please ask us about our specialty lens fees*)

**If you have vision insurance you may use your contact lens allowance to cover the contact lens exam fee. If you have any questions about how your vision plan applies, please ask us before your exam. We are glad to be of service!*

I understand that I have up to 30 days to return for follow-up care if I have any issues pertaining to the *comfort* or *vision* in my diagnostic (trial) contact lenses given today ______ (initial here)

If I return ***after 30 days*** for problems related to the *comfort* or *vision* in my contact lenses, I will be charged a contact lens exam fee, and the evaluation process will be re-initiated. ______ (initial here)

Your contact lens evaluation fee does not apply to conditions that are directly or indirectly caused by contact lens wear. Such conditions may include corneal ulcers, bacterial and viral conjunctivitis, SPK, GPC, etc. These medical conditions will be assessed an office visit and will be billed to your medical insurance carrier, or to you directly. I have read and understand the policy for contact lenses at Kyle Vision.

________________ (Name) ________________________ (Signature) __________ (Date)