



**Welcome to Bright Eyes Vision Clinic
Patient Information**

Name: _____ Birthdate: _____

Parents/Guardian Names (if minor child): _____

Address: _____

City, State, Zip: _____

Home Phone: () _____ Work: () _____

Cell: () _____ Number best to reach you: _____

Email address: _____

Marital Status: M S D Sex: M F

How did you hear about our office?

Doctor Referral/Name _____

Patient Referral/Name _____

Location Newspaper Internet Yellow pages InfantSEE Other: _____

Social Security Number:		
Occupation:		
Employer:		
School/ Grade:		
Do you have VSP (Vision Service Plan)?	Yes	No
Primary Insurance:		
Secondary Insurance:		
Primary Insured Name/ Birth Date:		
Primary Insured Phone:		
Emergency Contact:		
Relationship:	Phone:	

Please be sure you have filled out both sides.

Insurance Authorization, Financial & Privacy Policies

* I understand that if I am diagnosed with/or have symptoms of a medical condition such as: glaucoma, dry eye, double vision, headaches, strabismus, infection, corneal disorders, diabetes, amblyopia, cataracts, blurred vision, eye strain, dizziness, etc., my visit is considered a medical visit and will be billed to my medical insurance. Follow up visits will also be considered as a medical visit and will be billed to my medical insurance. I am aware that a routine/well vision eye exam (nearsighted, farsighted, astigmatism, etc.) will be billed if I have no medical symptoms or medical conditions. I authorize Bright Eyes Vision Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.

* I acknowledge that I received or was given access to a copy of the Notices of Privacy Practices for Bright Eyes Vision Clinic.

* I authorize any holder of medical information about me to be released to my insurance company needed to determine benefits and file claims. I request that insurance payment for any services furnished be made on my behalf to Bright Eyes Vision Clinic, PA. I understand that insurance is a contract between myself and my insurance company. Bright Eyes Vision Clinic cannot guarantee insurance benefits.

* I understand that I am responsible for charges not paid by my insurance plan and providing current insurance information prior to the start of my appointment. Due to most insurance companies providing, unreliable, inconsistent information regarding coverage, Bright Eyes does not check benefit levels prior to the appointment. I understand any remaining balance on my account after 30 days will accrue interest at annual rate of 18% and that I will be responsible for any reasonable costs associated with collection of past-due balances. I am aware that a service charge of \$30 will be applied for each NSF or stop payment checks. Bright Eyes Vision Clinic is not a provider for all insurance plans including MHCP(Minnesota Health Care Plans.)

* It is my responsibility to notify Bright Eyes Vision Clinic if I carry VSP insurance before ordering glasses as we may use a non-VSP lab.

*I understand that Bright Eyes Vision Clinic does not allow for returns or exchanges on eye wear.

CONTACT LENS EVALUATION FEES

As a contact lens wearer, additional tests are done for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and doctor each year to properly evaluate your contact lenses and eye health. Contact lens services are considered "non-medical" and are separate procedures that are typically not covered by insurance.

Contact Lens Yearly Evaluation Fee

starts at: \$49.00

A contact lens yearly evaluation is an evaluation of the same contact lenses that you currently wear, provided you had your eyes examined approximately one year ago. If your prescription needs to be changed during the year and you have already paid the evaluation fee, you will be charged the difference between the evaluation and the new fit. CRT lenses carry different fees.

New Contact Lens Evaluation Fees

All evaluation of new and existing patients will be charged as stated below. These fees will cover all services and visits needed in the fitting for 6 months. If patient does not return for their fittings within 6 weeks of their exam, additional fees may apply to finalize the prescription.

Soft Spherical:	\$65.00
Soft Toric, Extended Wear, Planned Replacements	\$85.00
Soft Spherical Monovision:	\$85.00
Soft Toric Monovision:	\$95.00
RGP Spherical:	\$85.00
Soft Bifocal:	\$95.00
RGP Torics, Bitorics, Monovision, Bifocals:	\$110.00
Soft Sphere/Toric Custom Lenses	\$155.00
Pediatric (Children age 6-10 or > +6.00/ -6.00 prescriptions):	\$155.00
Pediatric (Children under age 6):	\$185.00

If you are a brand new contact lens wearer, a \$25.00 fee will be added to any evaluation fees for an insertion, removal training and contact lens care training class.

I acknowledge that I am aware of the additional fees listed here regarding contact lenses and understand the Insurance Authorization, Financial & Privacy Policies.

Patient Name: _____ X _____ Date _____

Please be sure you have filled out both sides.



Patient Medical History

Welcome to our office. Many conditions can affect your vision and eye health. Please complete this form as completely as possible in order for us to provide you with the best care. This information is confidential and is for medical records only. Please be sure to complete both sides of the form.

Patient Name: _____ DOB: _____
Primary Care Provider: _____ Clinic: _____

Reason for Visit

Annual Exam Vision Therapy/Rehab Evaluation Contact lens evaluation Other: _____

Are you experiencing any of these EYE symptoms?

Redness Burning/Itching Tearing/Watery Mattering/Goopy Dry eye
 Blurred vision Eye strain Pain/Soreness Sensitivity to light Headaches
 Double vision Tired eyes Sandy/gritty feeling Burning/itching
 Problems with glare, reflections or driving at night? Losing your place, headaches or struggles when reading?

Other (explain): _____

Would you like information about Laser Vision Correction Surgery? Yes No
Would you like to non-surgically be able to see without glasses or contacts during the day? Yes No

Current Vision

When was your last eye exam? _____ Where? _____

Glasses: Do you currently wear glasses? Yes No *If yes, answer the questions below. If no, continue to contact lenses section.*

How old are your glasses? _____

How often do you wear your glasses? Full-time As needed for driving or reading Do not wear

Contact Lenses: Do you currently wear contact lenses? Yes No *If yes, answer the questions below. If no, continue to symptoms*

What is the brand and name of your contact lenses? _____

How often do you replace your contact lenses? Daily Weekly 2 weeks Monthly 3 months 6 months Annually

What solutions do you use to care for contact lenses? Renu Optifree Clear Care Other: _____

What would you change about your contact lenses? Comfort Fit Clarity of Vision Convenience

Other: _____

Social/Developmental History

What is your occupation/grade in school? _____

Do you work at a computer? Yes No If yes, how many hours per day are you on the computer? _____

What types or hobbies/activities/sports do you enjoy? Sewing Golf Fishing Swimming Contact Sports

Other: _____

Do you smoke? No Yes If yes, how much per day do you smoke? _____

Do you consume alcohol? No Yes If yes, how much do you drink per week? _____

Under 18: Typical letter grades: _____ School: _____

Does your child have any siblings? Yes No If Yes, please list names and ages:

Does your child struggle with reading? Yes No

Does your child struggle with mathematics? Yes No

Has your child had any delays in development? Yes No
(ie. Crawling, Walking, Talking, etc)

Family History Has anyone in your family been diagnosed with any of the following (check all that apply):

Blindness Glaucoma Amblyopia Cataracts Macular Degeneration Strabismus (eye turn)
 Diabetes High blood pressure Cancer: type _____ Family History Unknown

Do you NOW or have your EVER had any of the following conditions or illnesses?

Ocular/eye conditions

- Glaucoma Yes No
- Cataract Yes No
- Macular Degeneration Yes No
- Surgery, type: _____ Yes No
- Eye patching Yes No
- Inflammation of eyes Yes No
- Strabismus (eye turn) Yes No
- Amblyopia ("lazy" eye) Yes No
- Retinal Problems Yes No
- Injury to eyes Yes No
- Keratoconus Yes No
- Other: _____ Yes No

Constitutional Problems

- Developmental delays/disabilities Yes No
- Cancer, type: _____ Yes No
- Fatigue syndrome Yes No
- Other: _____ Yes No

Ears, Nose, Throat problems

- Hearing Loss Yes No
- Sinusitis Yes No
- Dry mouth Yes No
- Other: _____ Yes No

Neurological problems

- MS Yes No
- Epilepsy Yes No
- Cerebral Palsy Yes No
- Tumor Yes No
- Stroke/CVA Yes No
- Headache Yes No
- Autism Spectrum Disorder Yes No
- Other: _____ Yes No

Psychiatric problems

- Depression Yes No
- AD(H)D Yes No
- Anxiety Disorder Yes No
- Bipolar Disorder Yes No
- Other: _____ Yes No

Cardiovascular problems

- Hypertension Yes No
- Stroke/CVA Yes No
- Heart disease Yes No
- Vascular disease Yes No
- Congestive Heart Failure Yes No
- Other: _____ Yes No

Respiratory problems

- Cigarette smoker Yes No
- Asthma Yes No
- Bronchitis Yes No
- Emphysema Yes No
- Chronic obstruction Yes No
- Sleep apnea Yes No
- Other: _____ Yes No

Gastrointestinal problems

- Crohn's Yes No
- Colitis Yes No
- Ulcer Yes No
- Acid Reflux Yes No
- Celiac Disease Yes No
- Other: _____ Yes No

Genitourinary problems

- Kidney disease Yes No
- Prostate disease/cancer Yes No
- STD-herpetic/chlamydia Yes No
- Benign Prostate Hypertrophy Yes No
- Pregnant or Nursing Yes No
- Other: _____ Yes No

Musculoskeletal problems

- Arthritis Yes No
- Osteoarthritis Yes No
- Fibromyalgia Yes No
- Muscular dystrophy Yes No
- Ankylosing Spondylitis Yes No
- Osteoporosis Yes No
- Gout Yes No
- Other: _____ Yes No

Skin problems

- Eczema Yes No
- Rosacea Yes No
- Psoriasis Yes No
- Herpes Simplex/Cold Sores Yes No
- Herpes Zoster/Shingles Yes No
- Other: _____ Yes No

Endocrine problems

- Type 2 diabetes Yes No
- Type 1 diabetes Yes No
- Thyroid dysfunction Yes No
- Hormonal dysfunction Yes No
- Other: _____ Yes No

Blood/lymph problems

- Anemia Yes No
- Large-volume blood loss Yes No
- Ulcer Yes No
- High cholesterol Yes No
- Other: _____ Yes No

Allergy/immunologic problems

- Drug allergies Yes No
- Environmental allergies Yes No
- Rheumatoid arthritis Yes No
- Lupus Yes No
- Sjogren's syndrome Yes No
- Other: _____ Yes No

Other: _____

Have you had a concussion, brain injury or car accident? Yes No Dates: _____

List any medicine allergies: _____

List any medications you are currently taking and how often:

Other concerns/questions that you would like addressed today? _____

Signature _____ Date _____