Name:_____ **DOB:**_____ **Date:**_____

1. **Are you currently taking any medications?** ❒ **Yes** ❒ **No**

   Please List:_____

   _____

2. **Do you have the following?** ❒ **Medication Allergies** ❒ **Other Allergies (Food, Seasonal, Etc.)** ❒ **Latex Sensitivity**

   Please List: _____

3. **How many hours per day do you spend on the computer? _____hours/day**
4. **Are you interested in contact lenses today?** ❒ **Yes** ❒ **No** **(Contact lens evaluations are an additional charge)**
5. **Occupation/Hobbies** _____

Review of Systems **Do YOU have any of the following?**

Constitutional: ❒Developmental Disabilities ❒Cancer ❒Fatigue Syndrome ❒Other

ENT: ❒Hearing Loss ❒Sinusitis ❒Dry Mouth ❒Laryngitis ❒Other

Neurological: ❒Multiple Sclerosis ❒Epilepsy ❒Cerebral Palsy ❒Tumor ❒Stroke/CVA ❒Migraine ❒Other

Psychiatric: ❒Depression ❒Attention Deficit ❒Anxiety Disorder ❒Bipolar Disorder ❒Other

Cardiovascular: ❒High Blood Pressure ❒Stroke/CVA ❒Heart Disease ❒Vascular Disease ❒Congestive Heart Failure ❒Other

Respiratory: ❒Cigarette Smoker ❒Asthma ❒Bronchitis ❒Emphysema ❒Chronic Obstruction ❒Sleep Apnea ❒Other

Gastrointestinal: ❒Crohn's ❒Colitis ❒Ulcer ❒Acid Reflux ❒Celiac Disease ❒Other

Genitourinary: ❒Kidney Disease ❒Prostate disease/Cancer ❒STD-Herpetic/Chlamydia ❒Benign Prostate Hypertrophy ❒Pregnant ❒Nursing ❒Herpes ❒Chlamydia ❒Other

Musculoskeletal: ❒Osteoarthritis ❒Arthritis ❒Fibromyalgia ❒Muscular Dystrophy ❒Ankylosing Spondylitis ❒Osteoporosis ❒Gout

Integumentary: ❒Eczema ❒Rosacea ❒Psoriasis ❒Herpes Simplex/Cold Sores ❒Herpes Zoster/Shingles ❒Other

Endocrine: ❒Type 2 Diabetes Mellitus ❒Type 1 Diabetes Mellitus ❒Thyroid Dysfunction ❒Hormonal Dysfunction ❒Other

Hem/Lymph: ❒Anemia ❒Large-volume blood loss ❒Ulcer ❒High Cholesterol ❒Other

Allergic/Immune:❒Drug Allergies ❒Environmental Allergies ❒Rheumatoid Arthritis ❒Lupus ❒Sjogren's Syndrome ❒Other

Family History **Please indicate if any of the following conditions are present in your immediate family:**

Cancer:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Diabetes (Type 1):	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Diabetes (Type 2):	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Hypertension:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Hyperthyroidism:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Hypothyroidism:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Cataracts:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Macular Degeneration:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Glaucoma:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None
Other Eye Conditions:	❒Father	❒Mother	❒Brother(s)	❒Sister(s)	❒Son(s)	❒Daughter(s)	❒Unknown	❒None

Explain: _____

Horvath Vision Care Financial Policy*

It is the policy of Horvath Vision Care, Inc. to have a financial policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This Financial Policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our physicians participate with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by patients prior to leaving the office. We will not submit insurance claims if insurance is presented ***after*** the day of service. You would be given an itemized receipt to send in on your own.
- If a patient has insurance that we ***do not participate in,*** our office will be happy to provide an itemized receipt; ***however, payment in full is expected at the time of service.***
- It is the patient's responsibility to pay any deductible, co-payment, or portion of the charges as specified by the plan at the time of the visit. Any services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit.
- Payment for professional services and materials can be made with cash, credit card and or debit card.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsibility due to the lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and bring their insurance card and photo identification to each visit.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information that a carrier may need to process the claim. ***Specific coverage issues, however, can only be addressed by the insurance company.***
- In situations which a patient has routine vision coverage as part of their medical coverage and a separate vision plan/coverage, we reserve the right to choose which plan/coverage is to be used. The choice of coverage will be made so that is mutually beneficial to the practice and to the patient. Every attempt will be made to keep the patient's out of pocket costs at or near those associated with the separate vision plan.
- The adult accompanying any minor and the parents (or guardian of the minor) are responsible for payment at the time of service.

Horvath Vision Care, Inc. firmly believes that a good physician/patient relationship is based on understanding and good communication. Questions about financial arrangements should be directed to the Office Manager or Billing Coordinator.

By signing below, you agree to the terms of the above financial policies:

_____ _____

Patient Signature (or Guardian) **Date**

Insurance Authorization and Release*

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of benefits directly to Horvath Vision Care, Inc. I understand that I am responsible for any deductible, copay, share of cost, or service not covered by my insurance.

_____ _____

Patient Signature (or Guardian) **Date**

HIPAA Acknowledgment*

I am aware that Horvath Vision Care Inc. abides by the HIPAA privacy policy thereby keeping my personal and medical information confidential. Please let a staff member know if you would like a copy of the HIPAA policy.

_____ _____

Patient Signature (or Guardian) **Date**