JACOBSON ADVANCED EYE CARE

WELCOME TO OUR OFFICE

PLEASE PRINT Today's Date ___/___/_____

First Name: _____

Middle Initial: _____

Last Name: _____

(Please make sure it is your legal name)

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

E-mail Address: _____

Date of Birth: _____ Age: _____ M F

Spouse (or parent) name: _____

Other household members: _____

_____

Insurance policies are contracts between the patient and the insurance company. While we make every effort to work with your insurance company, ultimately it is your responsibility to make all payments to ***Jacobson Advanced Eye Care.***

Vision Insurance Company: _____

_____

Medical Insurance Company: _____

_____

Name of Insured: _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Insured's Last 4 of Social Security Number: ____

Language (please circle): English Other

If other, specify _____

Race: _____

Ethnicity (please circle one):

Hispanic or Latino Not Hispanic or Latino

How did you hear about our office?

_____

Do you use a smartphone? Y N

If yes, how many hours? _____

Do you use a tablet? Y N

If yes, how many hours? _____

Do you use a computer? Y N

If yes, how many hours? _____

Do you read books? Y N

If yes, how many hours? _____

Are you a gamer? Y N

If yes, how many hours? _____

Do you alternate your vision between two distances?

TV & Smartphone _____ hrs/day

TV & Tablet _____ hrs/day

TV & Computer _____ hrs/day

Computer & Reading _____ hrs/day

Hobbies: _____

PLEASE CIRCLE ALL THAT APPLY TO YOUR EYES:

Red	Burn	Itch	Tear	Discharge
Blurred	Strain	Pain	Light sensitivity	
Headache		Poor night vision		Double Vision
Total loss of vision		Flashes	Floaters	Dry Eyes

HAVE YOU EVERY HAD ANY OF THE FOLLOWING?

Glaucoma	Y	N
Cataract	Y	N
Macular Degeneration	Y	N
Inflammatory Disorders	Y	N
Patching	Y	N

List any eye surgery or injury & dates (such as Lasik, Cataract, Etc.)

_____

_____

Do you drink alcohol? Y N

If yes, list amount _____

Do you use tobacco? Y N

If yes, list amount _____

If yes, circle one: Cigarettes Pipe

Cigars Smokeless Other: _____

Smoking status (circle one):

CURRENT FORMER NEVER

May we contact your doctor (s), either via paper or electronically? Y N

List Primary Medical Doctor and any Specialists: _____

List Primary Medical Clinic: _____

DO YOU NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS OR DISEASES?

CONSTITUTIONAL

Developmental Disabilities	Y	N
Cancer	Y	N
Type _____		
Fatigue Syndrome	Y	N

EAR/NOSE/THROAT

Hearing Loss	Y	N
Sinusitis	Y	N
Dry Mouth	Y	N
Laryngitis	Y	N

NEUROLOGICAL

Multiple Sclerosis	Y	N
Epilepsy	Y	N
Cerebral Palsy	Y	N
Tumor	Y	N
Stroke/CVA	Y	N
Migraine	Y	N
Autism Spectrum	Y	N

PSYCHIATRIC

Depression	Y	N
Attention Deficit	Y	N
Anxiety Disorder	Y	N
Bipolar Disorder	Y	N

CARDIOVASCULAR

Hypertension	Y	N
Stroke/CVA	Y	N
Heart Disease	Y	N
Vascular Disease	Y	N
Congestive Heart Failure	Y	N

RESPIRATORY

Cigarette Smoker	Y	N
Asthma	Y	N
Bronchitis	Y	N
Emphysema	Y	N
Chronic Obstruction	Y	N
Sleep Apnea	Y	N

GASTROINTESTINAL

Chron's	Y	N
Colitis	Y	N
Ulcer	Y	N
Acid Reflux	Y	N
Celiac Disease	Y	N

GENITOURINARY

Kidney Disease	Y	N
Prostate Disease/ Cancer	Y	N
STD-Herpetic/ Chlamydia	Y	N
Benign Prostate Hypertrophy	Y	N
Pregnant	Y	N
Nursing	Y	N
Herpes	Y	N
Chlamydia	Y	N

MUSCULOSKELETAL

Osteoarthritis	Y	N
Arthritis	Y	N
Fibromyalgia	Y	N
Muscular Dystrophy	Y	N
Ankylosing Spondylitis	Y	N
Osteoporosis	Y	N
Gout	Y	N

INTEGUMENTARY

Eczema	Y	N
Rosacea	Y	N
Psoriasis	Y	N
Herpes Simplex/ Cold Sores	Y	N
Herpes Zoster/ Shingles	Y	N

ENDOCRINE

Type 2 Diabetes Mellitus	Y	N
Type 1 Diabetes Mellitus	Y	N
Thyroid Dysfunction	Y	N
Hormonal Dysfunction	Y	N

HEMOTOLOGIC/LYMPHATIC

Anemia	Y	N
Large-volume blood loss	Y	N
Ulcer	Y	N
Hypercholesteremia/ High Cholesterol	Y	N
Lymes	Y	N

ALLERGIC/IMMUNE

Drug Allergies	Y	N
Environmental Allergy	Y	N
Rheumatoid Arthritis	Y	N
Lupus	Y	N
Sjogren's Syndrome	Y	N

List Any Other Medical Conditions:

_____

_____

FAMILY MEDICAL **PLEASE CIRCLE IF YOUR FAMILY HAS/HAD ANY OF THE FOLLOWING:**

CANCER:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
DIABETES TYPE 1:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
DIABETES TYPE 2:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
HYPERTENSION:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
HYPERTHYROIDISM:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
HYPOTHYROIDISM:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER

FAMILY OCULAR

CATARACT:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
MACULAR DEGENERATION DISORDER:				**YES**	**NO**	**UNKNOWN**			
				If yes, please circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER
GLAUCOMA:	**YES**	**NO**	**UNKNOWN**	If yes circle:	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER

SIGNATURE: _____ DATE: _____

Jacobson Advanced Eye Care Assignment of Benefits Form

Name of Insured (print): _____ Medicare Identification# _____

1 **Signature on File:** I authorize use of this form on all my insurance submissions, (including Medicare if I am a Medicare beneficiary), release information to all my insurance companies and permit a copy of this authorization to be used in place of the original. I authorize my doctor to act as my agent in obtaining payment from my insurance company and understand payment will be made directly to Lee R. Jacobson, OD SC, dba Jacobson Advanced Eye Care. Coinsurance and deductibles are based upon the approval of the Medicare carrier or other insurance and I understand that I am responsible for those amounts determined by my insurance.

2 **Release of Information:** Jacobson Advanced Eye Care may disclose certain health information without my authorization. Such uses may be for treatment, payment or health care operations, which may include appointments, referrals to another doctor or clinic for treatment purposes, state or federal law purposes, public health purposes, prescribing glasses, contact lenses or medications. We may not disclose your information without your authorization for marketing activities, sale of health information or psychotherapy notes. By signing this document, I also acknowledge that I have received a copy of Jacobson Advanced Eye Care's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

3 **Financial Agreement:** I understand that I am financially responsible for any charges not covered by health or vision care plan benefits. Accordingly, the undersigned accepts full responsibility for all items or services which are determined by the health or vision care plan not to be covered, (i.e. Medicare patients- routine eye exams and refractions). The undersigned agrees to obtain necessary health care services authorizations and/or referrals prior to appointment.

Signature of Insured or Parent/Guardian: _____ Date: _____

Relationship to Insured: _____

About Your Insurance

There are two types of health insurance that may help pay for your eye care services. You may have one or both that our practice accepts:

1 Vision Care Plans (such as VSP)
2 Medical insurance (such as Medicare or Blue Cross/Blue Shield)

Vision Care Plans only cover routine vision exams to prescribe eyeglasses and contact lenses. Vision plans only cover basic screening for eye disease. They do **NOT** cover diagnosis, management or treatment of eye diseases. If a medical problem or disease is found, your medical insurance may need to be billed.

Medical insurance must be used if you have any eye injury, eye health problem (such as cataract) or systemic health problem (such as diabetes) that has ocular complications. Your doctor will determine if these conditions apply to you, but some are are determined by your previous health history.

If you have both types of insurance plans, it may be necessary for us to bill some services to the vision care plan and other services to the medical insurance.

Our doctor may determine it is necessary for you to return to our office for additional testing which may also be billed to the medical insurance.

If additional special testing is required, or if a **referral is needed**, you may need to contact you major medical insurance company to determine coverage.

We will bill your insurance plan for services if we are a participating provider for that plan. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Signature of Insured or Parent/Guardian: _____ Date: _____

MEDICATION FORM

May we contact your pharmacy or medical doctor's office, via either paper or electronically, if necessary, to obtain prescription and/or allergy history? Y N

List All Pharmacies: _____

List all drug allergies: _____

_____

If possible, please supply a list of your medications from your primary medical doctor. If not, please list all medications you are currently taking including: prescription, over-the-counter medications (example: aspirin) and herbal or vitamin supplements (examples: ginseng or Vitamin D).

DATE STARTED	NAME OF MEDICATION	DOSE	# TIMES PER DAY	REASON TAKING	DOCTOR NAME

COMMUNICATION AUTHORIZATION & RELEASE OF INFORMATION TO FAMILY MEMBERS OR OTHER INDIVIDUALS

Many of our patients allow family members such as their spouse, parents or others to request exam results. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have the results released to family members or other individuals, you must sign this form. By signing this form, I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and my not longer by protected by HIPPA.

Please indicate below the names and relationship of any individual Jacobson Advanced Eye Care may discuss your healthcare issues with. This authorization and release includes information communicated via phone, email, fax or in person.

*THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME WITH A WRITTEN LETTER

PLEASE LIST YOUR EMERGENCY CONTACT ON THE FIRST LINE

NAME	RELATIONSHIP	PHONE NUMBER
EMERGENCY:		

For patients with a **guardian**, please provide the guardian's name and authority:

Name: _____

Description: _____

of Authority Parent, Legal Guardian, Power of Attorney, Court Ordered Guardian, Etc.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

JACOBSON ADVANCED EYE CARE

PUPILLARY DILATION AND/OR ANESTHETIC DROP CONSENT

Our office routinely dilates every patient over the age of 50 or if symptoms require it to achieve the most comprehensive evaluation of the health of your eyes. Whether pupil dilation is necessary for every eye exam depends on the reason for your eye exam, your overall health and your risk of eye diseases.

Dilating the pupils may cause temporary blurring of your vision. We advise that you exercise caution in operating any equipment or machinery, including driving, until the effects have worn off.

Anesthetic drops are used during the pressure reading procedure. The effects of these drops should last approximately 5-10 minutes. Our office routinely takes a pressure reading on anyone 8 years of age and older.

Please check **TWO** of the following:

____ Yes, I give consent to have my eyes dilated.
____ No, I do not want my eyes dilated. (see below)
____ Yes, I give consent to have the anesthetic drops.
____ No, I do not want anesthetic drops. (see below)

In refusing to have these procedures done, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by these procedures.

Signature of patient: _____ Date: _____

Parent/guardian signature (if minor): _____

☐ Check if no parent/guardian available to sign