EyeCare of Western Oklahoma

WELCOME

Thank you for choosing our office for your eyecare needs. We're glad to help if you have questions.

All Patient Information is Confidential

Name:_____ Date:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Text OK?_____

Email:_____ Birthdate:_____

Patient's SSN:_____ Empolyer:_____

Primary Physician/Pediatrician:_____

Marital Status:_____ Children:_____

Preferred Method of Communication: ❒ Cell Phone ❒ Home Phone ❒ Text ❒ Email

Preferred Language: ❒ English ❒ Spanish ❒ Other: _____

Race:
- ❒ White
- ❒ Black or African American
- ❒ American Indian or Alaskan Native
- ❒ Asian
- ❒ Hispanic
- ❒ Other: _____

Preferred Pharmacy:_____ Phone:_____

Insurance Information

If you are using insurance, we need a copy of your medical and vision cards.
We treat both medical eye problems as well as vision care. Thank you.

Primary Member's Name:_____ Primary's Employer:_____

Primary's SSN:_____ Primary's Birthdate:_____

Your Eye Health and Vision are important to us.

Health History_____

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	❒	❒	Glaucoma	❒	❒
High Blood Pressure	❒	❒	Cataracts	❒	❒
Elevated Cholesterol	❒	❒	Turned Eye	❒	❒
Kidney Disease	❒	❒	Lazy Eye	❒	❒
Thyroid Disease	❒	❒	Eye Injury	❒	❒
Asthma	❒	❒	Eye Surgery	❒	❒ _____
Cancer _____	❒	❒	Blindness	❒	❒
Heart Disease	❒	❒	Dry Eye	❒	❒
Macular Degeneration	❒	❒	Other:		

Please indicate if any of the following conditions apply to you:

❒ Pregnant ❒ Drug Allergies ❒ Frequent Headaches
❒ Allergies ❒ Sinus trouble ❒ Smoker

_____

Please list all medications you are allergic to: ❒ None

_____

Medications you are currently taking: ❒ None ❒ List Provided

_____

Approximate Date of Last Eye Exam? 1 year 2 years >3years By Whom?_____

Do you currently wear glasses? ❒ Yes ❒ No if yes, when do you wear your glasses?

❒ All the time ❒ Reading/Near Work ❒ Distance tasks only
❒ Work Safety ❒ Computer wear ❒ Other, please explain

Are you planning on getting new glasses today? ❒ Yes ❒ No ❒ Unsure

Have you ever worn contact lenses? ❒ Yes ❒ No

Are you renewing your contact lens prescription today? ❒ Yes ❒ No ❒ Unsure

Do you work on a computer more than 4 hours a day? ❒ Yes ❒ No

Are you interested in Laser Vision Correction? ❒ Yes ❒ No

How did you become aware of our practice?
❒ insurance provider ❒ referred by other professional
❒ friend recommendation / co-worker whom: _____

Payment Information

I authorize you to bill my insurance for any applicable services or products, and I understand that payments for non-insured services are due the same day services are rendered. I also agree to pay a processing fee of 40% on any delinquent balance should my account go to collections.

Signature:_____

EyeCare of Western Oklahoma

Notice of Privacy Practice
Methods of Payments

No Insurance?

No Problem. EyeCare of Western Oklahoma offers a discount for all non-insurance patients for their Vision or Medical Exam. We also accept all major credit cards, Care Credit, cash or checks.

Vision Plans

Some vision insurance plans do not provide an insurance card. Vision plans (Examples: VSP, EyeMed, PVCS, etc.) usually include benefits towards glasses or contacts, however these plans often do not cover ALL services (examples: retinal photography, contact lens fittings, contact lens evaluations) performed at our office. Medical insurances generally do not cover these benefits. Medicaid (Soonercare) only allows glasses for patients less than 20 years of age and they do not cover contact lenses.

Medical Insurance

Refractions (checking vision) & the contact lens portion of the exam are not generally covered by medical plans. We can file your insurance on your behalf, but this does not guarantee payment and any balance will be paid by you. If your deductible has not been met for the year, you will be responsible for services rendered. We keep medical insurance information on file because we perform medical eye care. We use medical insurance for infections, foreign body removal, eye disease, treatments, etc.

We are glad to answer any questions regarding your insurance benefits. Thanks!

Please Sign Here – Privacy Practices

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices (available at the front desk).

Patient Name (please print): _____ Date: _____

Signature of Patient or Guardian: _____