Patient Information

Name:___________________________________ Sex: Male or Female Married? Yes or No

SSN:_______-______-________ DOB:______/_____/________

Mailing Address:_____________________________ Occupation:__________________________________

City/State/Zip:______________________________ Employer:____________________________________

Phone:______________________________________ Hobbies:_____________________________________

Email:______________________________________ Referral Source:______________________________

Emergency Contact:__________________________ Medical Insurance:____________________________

Emergency Phone:____________________________ Vision Insurance:_____________________________

Medical History

Last Eye Exam?________________________ Do you wear glasses? Y or N Do you wear contacts? Y or N

Are you Pregnant/Nursing?________Alcohol Use?________Tobacco Use?________

Please check only the conditions that apply to you or a member of your immediate family on a REGULAR basis:

	Self	Family		Self	Family
Blindness			Cancer		
Cataracts			Cholesterol Problems		
Dry Eyes			Depression/Anxiety		
Eye Allergy			Diabetes		
Eye Injury			Heart Problems		
Flashes/Floaters			Thyroid Problems		
Frequent Eye Infections			AIDS/HIV		
Glaucoma			Arthritis		
Lazy Eye			Headaches		
Macular Degeneration			Hepatitis (_____)		
Retinal Detachment			Blurred Vision		
Eye Surgery			Double Vision		
Asthma			Eye Strain		
Blood Pressure Problems			Red Eyes		

Medications:

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____

DRUG Allergies:

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Other:

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**See other side

PLEASE READ and **INITIAL** EACH SECTION

Initial

Notice of Privacy Practices Acknowledgement

______ By initialing, I acknowledge the full notice of privacy practices of Gallatin Valley Vision, LLC is available by request from our check in desk. I have read (or had the opportunity to read if I so chose) and understand the notice.

Is there anyone, besides yourself, that we may discuss your medical information with? If yes, please list:

Name: ____ Relation: ________________

Initial

Assignment of Release of Insurance

______ By initialing, I certify that I and/or my dependent(s) have coverage with the insurance company indicated in the patient profile and assign directly to Dr. Jessica Lemons all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Jessica Lemons may use and disclose my health care information to the insurance company(s) and their agents for the purpose of determining insurance benefits and obtaining payment for services and materials. Claims will be filed by HCFA or electronically. I understand that if Dr. Jessica Lemons bills my insurance on my behalf there is a **$5.00 administrative fee that is due at the time of service.**

Initial

Financial Policy

______ By initialing, I understand that fees are standard and based on the complexity of your visit. Payment in full is required at the completion of your exam. Insurance co-payments are due at the time of service. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled. All sales are considered final. Custom orders are non-refundable. In store credit may be offered on some orders. All orders must have at least a 50% payment made at the time the order is placed and any remaining balance must be paid in full before the order can be dispensed.

The following services are elective: you may choose BOTH, NEITHER, or EITHER.

Both services are recommended by the doctor. If you have elected no and the doctor feels it is necessary, this will be discussed during your exam.

Dilation Consent

Our doctor uses eye drops to dilate your pupils as part of a comprehensive eye evaluation. Pupil dilation allows the doctor to better view key structures of the eye, to determine if you have any disease that may affect your vision. These drops typically cause decreased reading vision and light sensitivity for about 3-4 hours. Usually, distance vision is minimally affected. **There is no additional fee for this service.**

Initial

______ Yes, I consent to having my eyes dilated today.

OR

Initial

______ No, I decline to be dilated. I understand that certain medical conditions that may affect my vision may not be detected by my refusal and I accept all risks and responsibility.

Digital Retinal Imaging Consent

Retinal imaging allows instant viewing of the back of the eye without pupil dilation to monitor the eye for change. This is similar to x-rays at the dentist. While taking the retinal photo does not replace the need to have your eyes dilated, it is strongly recommended that you have photos taken if you plan on declining dilation at today's visit. **This is a screening tool. The fee for this service will be $45.**

Initial

______ Yes, please perform the Digital Retinal Imaging.

OR

Initial

______ No, I do not wish to have the optional imaging performed.

Your signature indicates you understand and agree to all the terms & conditions contained in the above paragraphs.

Patient Name: __________________________________ Authorized Signature: ____________________________________

Date: _______________________________________ Relationship to Patient: ____