New Patient Information

Name: _____ **Preferred Name:** _____ **Date of Birth:** _____
First / MI / Last

Last 4 digits of SS#: _____ **Sex:** ☐ Female ☐ Male ☐ Other **Preferred Gender/Pronouns:** _____ ☐ declined

Preferred Phone (☐ Cell ☐ Home ☐ Work): _____ Optional Additional Phone: _____ ☐ Home ☐ Work ☐ Cell

Email: _____

Home Address: _____
Street City State Zip

Employer/School: _____ ☐ Full Time ☐ Part Time **Occupation/Grade:** _____

Spouse/Partner: _____ **Spouse/Partner Date of Birth:** _____

Ethnicity Hispanic or Latino Not Hispanic or Latino

Race American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Island / White / Other

Please circle your preferences:
Communication Call / Email / Text / Mail **Language** ASL / English / Spanish / Other_____

How did you hear about us?

Friend/Family Referral (please specify): _____ Professional Referral (please specify): _____

My Insurance Woodbury Chamber Stroll Magazine

Walk in/Drive by Internet Employer I am a previous patient Other: _____

Insurance

Primary Med. Insurance Company: _____
Policy Holder's Name or ☐ Self: _____
Policy Holder's DOB or ☐ Self: _____

Secondary Med. / Vision Ins Company: _____
Policy Holder's Name or ☐ Self: _____
Policy Holder's DOB or ☐ Self: _____

Primary Care Provider Name: _____ Primary Care Provider Clinic: _____

Vantage Point Eyes will be happy to file your insurance claim on your behalf. **However, any benefits quoted by us or relayed from your insurance carrier(s) are only an estimation of benefits, not a guarantee of coverage. A final determination cannot be made until a claim is processed by your insurance carrier(s).** While we are willing to check for you, knowing your insurance benefits and restrictions are ultimately your responsibility. If your insurance company or policy requires a referral or prior authorization, it is **your** responsibility to make sure that this is obtained before services are provided. If services provided are not covered by your plan or are not of the contractual obligation with that carrier, the bill remains your responsibility.

Signing below acknowledges the following:
*I have read and understand this form. I am signing it voluntarily.
*I was given the opportunity to read, have read, or had explained to me Vantage Point Eyes's Notice of Privacy Practice (HIPAA).
*I authorize the release of any information (including medical) needed to determine my benefits or the benefits payable for related services to my vision plan and/or insurance company and its agents.
*I authorize the use of standard email, in spite of the known risk involved, to communicate with me. Standard email is not secure & does not guarantee privacy.

Signature of Patient: _____ Date: _____

IF PATIENT IS UNDER 18 OR IN GUARDIAN'S CARE: If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions and consents for the minor. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

Representative Signature: _____ Relationship to Patient: _____

If Different Than Above, please provide: Phone: _____ ☐ Cell ☐ Home ☐ Work Additional Phone: _____

Address: _____
Street City State Zip

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

INSURANCE COPAYs & DEDUCTIBLES

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or Vantage Point Eyes. If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Vantage Point Eyes PLLC. I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my insurance denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. There will be no refunds for any professional services. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Vantage Point Eyes or my insurance carrier responsible for accidental laboratory breakage. **All fees, insurance co-pays, deductibles and contact lens evaluation fees (that insurance may not cover) are due at the completion of your exam.**

REFUNDS, REMAKES & WARRANTIES

Our office sells custom-made products and therefore cannot issue a full refund for glasses once they have been ordered. Cancellations will be subject to a restocking fee of 25% of retail price if the job has been started at the lab. We offer a one-time, 60-day period remake policy. This includes adding or removing lens options, non-adapts to certain lens designs or materials, frame changes, or changes in your prescription. Refunds will not be given on any material or lens design changes. Any additional remakes will be subject to fees.

Our Patient Satisfaction Guarantee We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided a copy upon request, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

AGREEMENT

_____

Date of Signing Guarantor/Patient Signature Witness

_____

Print Patient Name

Vantage Point Eyes

HEALTH TESTING NECESSARY FOR PROPER PATIENT CARE

Your vision insurance is defined as a minimal or basic eye examination. There is one vital health test that has always been part of our comprehensive eye health evaluation. In order to provide preventive eye health evaluations and preserve your sight by early detection of systemic (body) disease and eye disease, this test must be performed on all patients annually. Your vision insurance does not cover the cost of this vital test, yet they are extremely necessary.

The health tests being offered to you:

RETINAL PHOTOGRAPHY – Taking yearly colored photographs of the inside of the eyes is much like a dentist x-raying your mouth annually. The retinal photos document the internal health of your eyes and allow for accurate yearly comparisons. This enables the doctor to detect early eye health changes so that early treatment may be instituted to preserve your sight.

THE FEE FOR THIS HEALTH TEST IS $39

The fee is due today – the day service is rendered.

_____YES – I choose to have this preventive health test performed at $39. I understand the fees are due today.

_____NO – I choose to neglect the health test. I understand the medical risks involved due to my non-compliance.

DILATION - We highly recommend that you have your eyes dilated. Dilation allows for a more thorough evaluation to assess your risk for eye conditions such as glaucoma, macular degeneration, cataracts, diabetes, and other disorders. If you refuse dilation, there is a much greater chance that an eye disease could remain undetected. Dilating drops have a few side effects, all of which last approximately four hours. These include blurry near vision and increased sensitivity to sunlight. Blurry distance vision may occur, but patients usually feel comfortable driving with their glasses or contact lenses.

There is no additional cost for dilation.

_____ Yes, I agree to have my eyes dilated_____ No, I do NOT want my eyes dilated

_____ _____

Patient Name (Print) Date

_____

Patient Signature

ANY QUESTIONS REGARDING THIS PROCEDURE SHOULD BE DIRECTED TO YOUR DOCTOR.

755 Bielenberg Drive Suite 103 | Woodbury, MN 55125

P ● 651-504-5901 | www.vantagepointeyes.com | F ● 651-504-5902

History Form

Name: _____ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

Reason for Visit:_____

Date Last Eye Exam: ____/____/_____ Clinic / Eye Doctor's Name:_____

Do you wear **glasses**? Yes / No All the time Occasionally Office Work Reading Only Driving Only

Do you wear **contacts**? Yes / No Brand:_____ Daily Biweekly Monthly

Do you wear **sunglasses**? Yes / No Occasionally Driving Only Would Like To Start Wearing Sunglasses

Visual Demands

How many hours per day do you use digital **screens** (computer, cell phone, tablet, TV)? _____

What are your **Activities/Hobbies**: ☐ Reading ☐ Golf ☐ Fishing ☐ Sports ☐ Outdoors Other_____

Eye History

Have you ever had Eye Surgery or Injuries? Yes / No If yes, explain: _____

Have you ever been diagnosed with: ☐ Cataract ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment

☐ Amblyopia ☐ Strabismus ☐ Other _____ Approximate year of diagnosis: _____

Check all that apply:

☐ Blurred Vision-Distance	☐ Floaters or Spots	☐ Burning Eyes	☐ Light Sensitivity
☐ Blurred Vision-Near	☐ See Flashes	☐ Itchy Eyes	☐ Glare/Halos
☐ Eye Strain	☐ Loss of Vision	☐ Dry Eyes	☐ Poor Night Vision
☐ Headaches	☐ Double Vision	☐ Red Eyes	☐ Need more light to see
☐ Computer Related Eye Discomfort		☐ Watery Eyes	☐ Changes in Color Vision

Pregnant or Nursing

If applicable to you: are you currently **pregnant or nursing**? Yes / No

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

Personal Health History Please indicate your medical conditions and any medications that you take.

Allergies to Medications:

_____

Environmental Allergies:

_____ None: _____

Cardiovascular ___none
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other _____

Medications:_____

Integumentary: ___none
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other _____

Medications:_____

Constitutional ___none
- ☐ Cancer
- ☐ Developmental Disability
- ☐ Other _____

Medications:_____

Respiratory ___none
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Other _____

Medications:_____

Endocrine ___none
- ☐ Insulin Dependant Diabetes
- ☐ Non-Insulin Dependent Diabetes
- ☐ Thyroid Problem
- ☐ Other _____

Medications:_____

Ear/Nose/Throat: ___none
- ☐ Chronic Sinusitis
- ☐ Hearing Loss
- ☐ Upper Respiratory Infection
- ☐ Other _____

Medications:_____

Gastrointestinal: ___none
- ☐ Colitis
- ☐ Crohn's
- ☐ IBS
- ☐ Other _____

Medications:_____

Hematological: ___none
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other _____

Medications:_____

Neurological: ___none
- ☐ Epilepsy
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Other _____

Medications:_____

Genitourinary ___none
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD- Herpetic/Chlamydia
- ☐ Other _____

Medications:_____

Immunologic: ___none
- ☐ Lupus
- ☐ Neurofibromatosis
- ☐ Rheumatoid Arthritis
- ☐ Other _____

Medications:_____

Psychiatric ___none
- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Other _____

Medications:_____

Musculoskeletal: ___none
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Other _____

Medications:_____

Alcohol Use Y / N Amount/Wk:___

Tobacco Use Y / N Amount/Day:___

Please list any Medication and/ or drugs that you take (including herbal) that are not listed above:

_____

_____

Family Health History (living or deceased): O Unknown Family History

Y/N	High Blood Pressure —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Diabetes —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Cancer —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Heart Disease —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Thyroid Disease —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Glaucoma: —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Macular Degeneration: —-------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Cataracts: —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Retinal Detachment:----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Blindness: —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____
Y/N	Crossed Eyes: —----------	Father	Mother	Brother	Sister	Son	Daughter	Other _____

Other: _____