WELCOME TO MARTINEZ EYE ASSOCIATES

NAME_____ DATE OF BIRTH ____/____/____ AGE ____

ADDRESS_____ CITY/STATE/ZIP_____

PHONE (H)_____ PHONE (C)_____ EMAIL _____

ARE YOU HERE FOR:

EYE EXAMINATION: ☐ CONTACT LENS EXAMINATION: ☐ OTHER: _____

Describe the vision problems you are experiencing if any? _____

Last Eye Exam _____ Last Contact Lens Exam _____ Brand of Contacts_____

VISION INS: _____ MEDICAL INS:_____

PRIMARY INSURED SSN/ID:_____ PRIMARY INSURED NAME:_____

PRIMARY'S DOB:_____ EMPLOYER NAME:_____

Review of Systems. Do you have any of the following: Please check all that apply to you.

Eyes
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity

- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Stye
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detatchment

Endocrine
- ☐ Non Insul. Diabetes
- ☐ Insul. Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Cardiovascular
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ears/Nose/Throat
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Family Medical History: Check the conditions that apply, and list the relation to yourself (i.e. Maternal Grandmother, Father, etc.)

- ☐ Blindness _____
- ☐ Cataracts _____
- ☐ Macular Degeneration _____
- ☐ Glaucoma _____
- ☐ Retinal Detachment _____
- ☐ Crossed Eyes _____
- ☐ Lupus _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Arthritis _____
- ☐ Thyroid Disease _____

List of medications: _____

_____

Drug Allergies _____

*See Back Page Please

TREATMENT CONSENT

I hereby agree and consent to the treating physician and employees of the office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations, dilation, contact lens fitting and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partners, associates, and consultants. My presence at each future appointment implies and confirms my ongoing consent for treatment.

Non-Covered Services/Refractions

There may be services that your insurance policy does not cover. Examples of non-covered services include retinal imaging, visual field, refraction, and contact lens fitting. Please understand that if you decline the refraction, we will be unable to prescribe new glasses for you or prescribe a change in your existing glasses since the refraction is the test necessary to determine your glasses prescription. We will also lose the ability to evaluate your best correctable vision in order to rule out decreased vision that may be caused by a medical condition. The refraction is NEVER a covered service by Medicare and rarely covered by private insurance.

Financial Agreement/Assignment of Benefits

Martinez Eye Associates is a participating provider for most private insurance companies and will file your insurance claim for all covered services. Because we are a participating provider for most insurance companies, we have a contracted amount that the insurance company has agreed to pay us for any covered service or procedure. If you have a co-payment, coinsurance and/or a deductible we require that you pay these amounts on that date of service. In the unlikely event that an overpayment occurs, it will be reimbursed appropriately to either your insurance company or to you within 30 days. If your insurance company requires a referral, we ask that you obtain a referral prior to your appointment.

Release of Information

Martinez Eye Associates may disclose all or any part of your medical record and financial ledger to any person, corporation or insurance company to provide you with medical treatment or services or to obtain reimbursement for services rendered within HIPAA regulations.

HIPAA notice of privacy practices

I acknowledge that Martinez Eye Associates has offered me the opportunity to review the HIPAA Notice of Privacy Practices.

SIGNATURE _____