



**PATIENT INFORMATION**

Patient Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Widow  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Spouse or Parent Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
**Referring Optometrist / Physician:** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person responsible for this account: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**INSURANCE PLEASE PRESENT COPY OF YOUR INSURANCE CARDS**

Primary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING:**

**PREFERRED LANGUAGE:**  English  Spanish  Other  
**RACE:**  American Indian/Eskimo  Asian/Pacific Islander  
 African American  White  Other  
**ETHNICITY:** Hispanic/Latino Not Hispanic/Latino

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

I hereby authorize the physicians and staff of Sweeney Eye Associates to perform such treatments to me as may be prescribed by any attending physician during any and all of my treatments at Sweeney Eye Associates. (If a minor) I hereby authorized the physician to treat my child as deemed medically necessary.

**X**  
\_\_\_\_\_  
**SIGNATURE / RESPONSIBLE PARTY** **PRINT NAME** **DATE**

<b>MEDICAL INFORMATION</b>	<b>Date:</b>
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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current visual problems \_\_\_\_\_

List all eye drops you are currently using: \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ How old are they? \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_ How long? \_\_\_\_\_  Hard  Soft

**Are you currently living in a skilled nursing facility?**  Yes  No If **yes:** Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

**FAMILY HISTORY:** List family member

Cataracts _____	Retina Disease _____
Glaucoma _____	Diabetes _____
Lazy Eye/Amblyopia _____	
Crossed Eye/Strabismus _____	
Other Eye Disorder _____	

Does your vision bother your ability to: (check all that apply)

Drive  Read  Watch TV  Cook  Dress  See labels on medications

Do you live  Alone  with spouse  Family member  other \_\_\_\_\_

Do you require any of the following:  Walker  Cane  Scooter  Wheelchair

What are your hobbies? \_\_\_\_\_

How would you describe your general health and well-being?

Excellent  Good  Average  Fair  Poor

Do you have an interest in the following?  Multifocal Intraocular Lens  LASIK

**Previous Ocular Surgeries:**

	Date
	Date
	Date
	Date

**All Other Surgeries:**

	Date
	Date

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_



**PAST HISTORY & REVIEW OF SYMPTOMS**  
**Do you have or are you taking Medication for any of the following:**

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Sudden Loss or Change in Vision?			Neuropathy		
Blurring at Distance or Near?			Arthritis		
Dry, Itchy, Scratchy Eyes?			Artificial Joints		
Excessive Tearing or Discharge in Eyes?			Skin Rash		
Double or Distorted Vision			Shingles		
Redness			Seizures		
Swelling of Eyelids			Headaches		
Dry Mouth			Stroke/TIA		
Sjogrens			Multiple Sclerosis		
Hearing Loss			Memory Loss		
Heart Attack When:			Depression / Bipolar		
Heart Surgery When:			Diabetes		
High Blood Pressure			Insulin / Pills		
Low Blood Pressure			Kidney Disease		
Pacemaker			Dialysis		
Chest Pain			Thyroid Disease		
Irregular Heart Beat			Prostate		
Blood Clot			Anemia		
Congestive Heart Failure			Bruise Easily		
Coronary Artery Disease			Bleeding Problems		
Blood Thinners			HIV/AIDS		
High Cholesterol			Sickle Cell		
Asthma			Lupus		
Cough			Addison's Disease		
COPD			Sleep Apnea		
Emphysema			Do You Use a CPAP Machine		
Bronchitis			Heartburn / Acid Reflux		
Tuberculosis			Joint Pain		
Oxygen Use			Numbness of Limbs		
Hiatal Hernia			Weakness of Limbs		
Jaundice			Hepatitis A / B / C		
Ulcers			Cirrhosis		
Cancer			Recreational Drug Use		
Type of Cancer:			Name of Drugs:		
Are You Receiving Cancer Treatment			Cold or Flu Symptoms		

\*\*\*\*\*OFFICE USE ONLY\*\*\*\*\*

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<input type="checkbox"/> Reviewed History & ROS	Physician Signature: _____	Date: _____
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Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Please list all current medications and supplements including over the counter**

Medication Name and Dosage	Frequency	Route <i>Office Use Only</i>

**Drug Allergies:**  No Known Allergies  
Please enter all medication allergies  
\_\_\_\_\_

**Pharmacy** \_\_\_\_\_ Mail Order \_\_\_\_\_  
Address (cross streets) \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

- I give Sweeney Eye Associates permission to upload my prescription history YES / NO**
- Have you ever received a pneumonia vaccination? YES / NO**
- Have you received a flu shot this calendar year? YES / NO**
- Do you drink alcohol? YES / NO**     Drinks per day \_\_\_\_\_
- Do you use tobacco?** (i.e. cigarette, cigar, snuff) **YES / NO**     Packs per day \_\_\_\_\_



**FINANCIAL POLICY**

Thank you for choosing Sweeney Eye Associates for your eye care needs. We are committed to providing you with the highest level of service and quality care. In order to achieve these goals, we need your assistance and understanding of our financial policy. It is strongly recommended that you understand the extent of coverage that is available under your specific plan design. If you are not familiar with your insurance coverage, we suggest that you discuss the policy with your employer or insurance company before charges are incurred. Ultimately, any financial liability rests with the patient.

**Insurance Notification**- We ask that you provide to us a current insurance identification card. If a claim is denied due to wrong information provided, we will bill you directly for services rendered.

**Examination**- Not all exams are the same. Different diagnostic testing procedures may be performed based on your ocular complaints. You may be asked to return for additional testing. We will inform you during your exam if additional testing or procedures will need to be performed. The fees associated with these procedures will be discussed with you on your arrival or during your exam. If you have not been informed of additional fees, please ask our staff **prior to the procedure**. These procedures may or may not be covered by your insurance plan, or may fall under your deductible.

**Refraction**- A refraction is a procedure that determines if your visual complaints can be corrected with a prescription for glasses. Sometimes if glasses cannot correct your vision, then additional tests may need to be performed to determine the cause. If you are a new or established patient and have visual complaints, a refraction will be performed. The doctor is the only person that can determine if a refraction is necessary based on your visual complaints. This procedure is considered separate from your exam and **not covered by most insurance companies**.

**Co-Payment/Deductible**- Some ocular office visits may only require that you pay a co-payment at the time of service. Other insurance companies may apply the visit to your deductible. We will collect your co-payment and/or deductible amounts at the time of your visit based on the insurance information given to us by your insurance company. Any disputes with your insurance company must be handled by you and your insurance company or employer.

**Referrals/Authorizations**- Managed care plans require referral authorizations. This must be on hand the day of your visit in order for us to submit a claim and this is your responsibility to obtain. If you wish to be seen without a referral, you are responsible for payment on the day of your exam or you can reschedule once the referral is received.

**Routine Eye Care or Medical Eye Care**- Our office participates with most major insurance plans. We provide MEDICAL and SURGICAL ophthalmic care as well as ocular vision exams for glasses. Please note that many insurance plans do not cover vision exams when there is not a medical reason for the exam. This is what an insurance plan calls ROUTINE or ANNUAL exam for glasses. If your insurance plan does not cover ROUTINE or ANNUAL ocular exams, you are responsible for payment.

**Surgical Fees**- We will determine your financial responsibility due to Sweeney Eye Associates prior to your scheduled surgery. This may include any co-payments, co-insurance and/or deductible amounts quoted to us by your insurance carrier, **which will be collected at least 1 week prior to your scheduled surgery**. All surgical facility fees and anesthesia fees are separate from Sweeney Eye Associates and are collected from the Surgical Facility and the Anesthesiologist.

**Outstanding Balances**- Payment in full is expected for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will be happy to work out a payment plan with you. A payment made by check that does not clear your bank will result in a \$25.00 fee. This fee along with your outstanding balance must be paid by cash, credit card or cashier's check.

X  
SIGNATURE / RESPONSIBLE PARTY

PRINT NAME

DATE



**PATIENT AUTHORIZATION / ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare, Medicaid, or other Commercial Insurance benefits be made on my behalf to Sweeney Eye Associates for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor. **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay and for any non-covered services not payable and/or I am responsible for any Commercial Insurance copay, deductible or co-insurance for any non-covered services.**

**MEDIGAP OR OTHER SECONDARY INSURANCE**

I also request that payment of Medigap benefits or other secondary insurance be made either by me or on my behalf to Sweeney Eye Associates, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. **I am responsible for any deductible, copay, co-insurance and/or any non-covered procedures.**

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare Benefits have been relinquished.

X  
\_\_\_\_\_  
**SIGNATURE / RESPONSIBLE PARTY**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**DATE**



**NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. Copies of our Privacy Practices are located on laminated pages in the front of our office and at our check in counter for your review.

**I have been provided a copy of or access to the Notice of Privacy Practices.**

**PREFERRED METHOD OF COMMUNICATION**

_____ Home	May we leave a message	YES / NO
_____ Cell phone	May we leave a message	YES / NO
_____ Work	May we leave a message	YES / NO
_____ Text	May we send you text messages	YES/NO

**AUTHORIZATION TO DISCUSS MEDICAL INFORMATION**

I authorize Sweeney Eye Associates' physicians and/or staff members to discuss my medical care with the individual(s) listed below:

_____	_____
Name	Relationship

_____	_____
Name	Relationship

<b>X</b>	_____	_____	_____
<b>SIGNATURE / RESPONSIBLE PARTY</b>	<b>PRINT NAME</b>	<b>DATE</b>	

**Precaution Notice Regarding Dilating Drops**

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye and to diagnose your condition.

Dilating drops blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist/optometrist to predict how much your vision will be affected.

We provide disposable sunglasses that help to block the sensitivity to bright light. You will need to use caution while walking or going up or down stairs. Because driving may be difficult immediately after an examination, you may want to make arrangements for someone to drive you.

Adverse reaction, such as acute angle-closure glaucoma may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and understand the precautions listed above.

<b>X</b>	_____	_____	_____
<b>SIGNATURE / RESPONSIBLE PARTY</b>	<b>PRINT NAME</b>	<b>DATE</b>	