BEHLER
EYE & LASER CENTER

NEW PATIENT INFORMATION

PATIENT INFORMATION

Name _____ Date ____/____/____

Address _____ Home Phone ____-____-_____

City, State, Zip _____ Work Phone ____-____-_____

Social Security _____-_____-_____ Sex M ◯ F ◯

Email _____ Birthdate ____/____/____

Primary Physician _____ Last Medical Exam ____/____/____

Last Eye Doctor _____ Last Eye Exam ____/____/____

MEDICAL HISTORY

Reason for today's visit _____

Do you have allergies to medications _____

List any medications you are currently taking _____

Are you pregnant or nursing Yes ◯ No ◯

VISION CARE HISTORY

Do you currently wear glasses? No How old is your current pair of lenses? _____

Do you currently wear contact lenses? No How old is your current pair of lenses? _____

Type of contact lenses? Disposable Are you interested in contacts today? No

FAMILY HISTORY

Have you or a family member had any of the following:

	YES	NO	RELATIONSHIP
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Lazy Eye	☐	☐	_____
Retinal Detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other	_____		

*If you answered **YES** to any of the above or have a condition not listed, please explain and list medications* _____

_____

_____

_____

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INSURANCE INFORMATION

Name of Policy Holder _____ D.O.B ___/___/___

Primary Insurance _____

Group # _____ ID/Policy # _____

Secondary Insurance _____

Group # _____ ID/Policy # _____

Are you personally responsible for the payment of your fees? ○ ○

If not, who is? Name _____ Relationship _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Scott Behler, M.D., P.A. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage my signature authorizes my doctor to act as my agent above. **If my insurance does not cover any portion of my visits I further acknowledge that I am responsible for my payment of services rendered.**

_____ _____

Lifetime Patient Signature Date

What is a refraction?

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

Why is it sometimes necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, a refraction is an essential part of an eye exam; however, Medicare and most insurance companies DO NOT cover the charge for a refraction.

Will I be notified in advance if I need it?

Yes, ONLY the doctor or a technician is qualified to tell you if the procedure is necessary. They will let you know if the procedure is necessary BEFORE it is done. You will be given the option to accept or decline this service.

It is important to understand that if you decline we may not be able to determine the cause for your decrease in vision.

How much is the procedure?

Our office policy is to charge **$40.00** for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. If you insurance pays the fee we will gladly refund you this prepaid **$40.00** amount once we receive payment from your insurance.

NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor's and technician's time and effort in achieving this process.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay and deductible are spate from, and not included in, the refraction fee.

_____ _____

Patient Signature Date

How did you hear about us?: _____

BEHLER
EYE & LASER CENTER

REVIEW OF SYSTEMS

PATIENT INFORMATION

Name _____ Date ___/___/___

Address _____ Home Phone ___-___-____

City, State, Zip _____ Work Phone ___-___-____

Email _____ Birthdate ___/___/___

NEUROLOGICAL	Yes	No
Headaches	○	○
Migraines	○	○
Seizures	○	○
EYES		
Loss of Vision	○	○
Blurred Vision	○	○
Distorted Vision / Halos	○	○
Loss of Side Vision	○	○
Double Vision	○	○
Dryness	○	○
Mucous Discharge	○	○
Redness	○	○
Sandy/Gritty Feeling	○	○
Itching	○	○
Burning	○	○
Foreign Body Sensation	○	○
Excess Tearing	○	○
Glare/Light Sensitivity	○	○
Eye Pair on Soreness	○	○
Chronic Infections	○	○
Flashes / Floaters	○	○
Tired Eyes	○	○

ENDOCRINE	Yes	No
Thyroid	○	○
Lymphatic/Hematologic		
Anemia	○	○
EARS, NOSE, MOUTH, THROAT		
Allergies	○	○
Sinus Congestion	○	○
Runny Nose	○	○
Post-Nasal Drip	○	○
Chronic Cough	○	○
Dry Throat/Mouth	○	○
RESPIRATORY		
Asthma	○	○
Chronic Bronchitis	○	○
Emphysema	○	○
VASCULAR/CARDIOVASCULAR		
Diabetes	○	○
Heart Pain	○	○
High Blood Pressure	○	○
GASTROINTESTINAL		
Constipation	○	○
GENITOURINARY		
Genital/Kidney/Bladder	○	○

If you answered YES to any of the above or have a condition not listed, please explain and list medications _____

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HIPAA – NOTICE OF PRIVACY PRACTICES

Patient _____ DOB: ____/____/____ Date: ____/____/____

I hereby acknowledge that I received Behler Eye and Laser Center's Notice of Privacy Pracices.

_____ _____

Patient Signature Date

I may be contacted by phone in the following manner (check all that apply):

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

- ☐ Please leave a detailed message
- ☐ Please leave a call back number only
- ☐ Please leave a message with my:
  - ☐ Spouse: _____
  - ☐ Caregiver: _____
  - ☐ Adult Children: _____
  - ☐ Other: _____

Persons who may receive information about my care are: _____

_____

_____

Additional HIPAA compliance notification information is available at your request

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Name:_____ Date of Birth_____

Current Eye Medications: (Please list)

□ None

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list and include any aspirin or vitamins)

□ None

Medication name	Dose	Directions	Reason for taking	Prescriber name

Patient/Parent or Guardian Signature_____ Date_____