Patient Information

Patient's Name (please print)________________________________ Appointment Date____________________

Birth Date______________ Male or Female Home Phone______________________ Cell Phone_______________________

Street Address________________________________ City_____________ State_______ Zip Code_________

What is the purpose of your examination today? Please explain

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Vision Insurance ______________________________

Medical Insurance ______________________________

CONSENT TO TREAT AND BILL INSURANCE

I hereby request examination and treatment by VISION & EYE CARE, P.A and/or PAUL A. MENDOZA, O.D. I agree to be billed for non-covered services and/or copays/deductibles. I agree to be billed for all fees if no benefits are available through my insurance company. I agree it is not the responsibility of Vision & Eye Care to verify my benefits. Any verification of benefits performed by VECPA as a courtesy are not binding. I understand my insurance company determines copays, deductibles and amounts due to VECPA. I understand ultimately it is my responsibility to verify my medical/vision benefits.

I have been informed that VISION INSURANCE/EXAMINATIONS ONLY COVERS ROUTINE VISION CARE for the purpose of prescribing glasses or contacts and does NOT COVER diagnosis, treatment & management of eye disease, injuries, contact lens complications etc. MEDICAL INSURANCE covers treatment & management of eye disease, injuries contact lens complications, etc.

I have been informed the fees for ROUTINE VISION CARE is separate from MEDICAL FEES. I AGREE TO BE RESPONSIBLE FOR ALL FEES INCURRED. Payment for services are due upon rendering of care. Payment programs are available thru "CareCredit". *VECPA reserves the right to send unpaid balances for services rendered to collection agencies.* All my questions regarding vision/medical coverage have been answered to my satisfaction and understanding.

________________________________ ________________________________ ____________

Print Name of Responsible Party Signature of Responsible Party Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Vision & Eye Care, P.A. (VECPA) make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that: (Please initial selection)

____I have read or had explained to me VECPA's Notice of Privacy Practice and agree to continue my care with VECPA under said terms.

____I was given an opportunity to read VECPA's Notice of Privacy Practices and declined but wish to continue my care with VECPA under the terms of VECPA's privacy policies.

____I have read or had explained to me VECPA's Notice of Privacy Practice and do not wish to continue my care with VECPA under said terms.

____The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

________________________________ ______________

Patient Name (Print) Date

If you are signing as a personal representative of the patient, please indicate your relationship

________________________________ ____________________

Patient/Representative Signature Relationship to Patient

PATIENT MEDICAL & OCULAR HISTORY

Name ______________________________ Date ________________ Date of Birth ____________

Referring Physician ____________________

ALLERGIES TO MEDICATIONS **None**

MEDICATIONS (please list current medication list) **None**

EYE MEDICATIONS (please list current eye drops) **None**

PAST MEDICAL HISTORY/HOSPITALIZATIONS **None**

PAST OCULAR HISTORY **None**

Last Eye Exam Doctor's Name

FAMILY OCULAR HISTORY **None**

SOCIAL HISTORY Single/Married/Widowed/Divorced/Other

Do you smoke? Yes or No Do you drink? Yes or No Do you take drugs? Yes or No

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Review of Systems If you are currently experiencing any of the following problems, please circle and explain:

CONSTITUTIONAL: fatigue, fever, night sweats, weakness, weight gain, weight loss, other: None

CARDIOVASCULAR: arrhythmia, calf pain, chest pressure/discomfort, irregular heart beat, palpitationLeg swelling None

RESPIRATORY: asthma, cough, shortness of breath, coughing of blood, wheezing, other: None

GASTROINTESTINAL: pain, constipation, decreased appetite, diarrhea, dysphagia, heart burn, increased appetite, nausea, vomiting, other: None

GENITOURINARY: Painful urination, irregular menses, urethral discharge, urgency, other: None

MUSCULOSKELETAL: arthralgias, back pain, gait disturbance, stiffnessmuscle cramping, muscle weakness, other: None

INTEGUMENTARY: hives, itching skin, nail changes, rash, skin changes, skin nodules, skin sores, ulcer, other: None

NEUROLOGICAL: balance disturbances, dizziness, weakness, headache, memory difficulty, numbness other: None

PSYCHIATRIC: depressed, emotional changes, frequent nightmares, hallucinations, insomnia, irritability, Nervousness, stress, other: None

METABOLIC/ENDOCRINE: cold/hot intolerance, excess thirst, excess hunger, frequent urination, other: None

HEMATOLOGIC AND LYMPHATIC: bleeding, bruising, lymphadenopathy, tender lymph nodes, other: None

IMMUNOLOGICAL: environmental allergies, food allergies, seasonal allergies, other: None

HEENT: bulging eyes, hearing loss, hoarseness, lump in neck nasal congestion, sinus problems, sore throat, ears ringing, dizziness, other: None

This form completed by: ______________________ ______________________ Date ____________

Print Name Signature

Reviewed all elements of case history as recorded on ___/___/___, no changes except as noted. ______________ ________

Paul A. Mendoza, O.D. Date