# Complete Family Eyecare and Optique, P.C.
## Dr. Scott A. Baylard

Welcome to Complete Family Eyecare. Thank you for choosing us for your eye care needs. Please take a moment to complete the following information as accurately as possible.
If you have any questions, please do not hesitate to ask.

GENERAL INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Rev. Preferred Language: ☐English ☐Spanish
☐Male ☐Female

Name (Last, First, M.I.) ______________________ Preferred Name ____________
Street Address ______________________________________________
City ____________________ State________ Zip Code____________
Home Phone # (_____)____________________ Work Phone # (_____)____________________
Cell Phone # (_____)____________________ Ok to Text? ☐Yes ☐No
Date of Birth ____________________ Age ________ Social Security # ____________________

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black or African American
☐Hispanic ☐Native Hawaiian/Other Pacific Islander ☐White

Marital Status: ☐Married ☐Single ☐Divorced
☐Legally Separated ☐Widowed

Email ____________________________ Communication Preference: ☐Email ☐Postal ☐Tel.
Parent/Guardian ____________________ Person Responsible for Account ____________________
Emergency Contact (Name) ____________________ Emergency Phone # (_____)____________________
How were you referred to our office?
☐ Phone Book ☐ Advertisement ☐ Insurance Listing ☐ Internet ☐ Drive By
☐ Patient (please name) ____________________ ☐ Other ____________________

Primary *VISION* Insurance Information

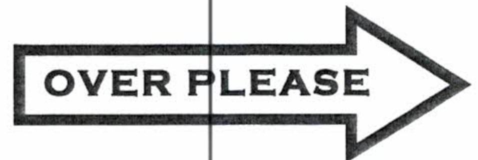
**❖To file on your behalf we MUST have this section completed❖**

Name of Primary **VISION** Insurance ______________________________
Full Name of Primary Insured ______________________________
Date of Birth of Primary Insured ______________ ID/Social Security # of Primary Insured______________

Primary *MEDICAL* Insurance Information

**❖To file on your behalf we MUST have this section completed❖**

Name of Primary **MEDICAL** Insurance ______________________________
Full Name of Primary Insured ______________________________
Date of Birth of Primary Insured ______________ ID/Social Security # of Primary Insured______________



# PATIENT HISTORY & INFORMATION

**GENERAL HISTORY**

What is the main reason for today's exam? ____________________

When was your last EYE exam? __________ When was your last general HEALTH exam? __________

Past illnesses/injuries/surgeries____________________

Current Medications (including prescribed, over the counter or vitamins)____________________

____________________

Medications you are allergic to ____________________

Other allergies (food, seasonal, etc...) ____________________

Do you wear contacts? ☐ yes ☐ no

If yes, how many hours per day? __________

If no, are you interested in wearing contact lenses? ☐ yes ☐ no

Current occupation ____________________ Employer ____________________

**EYE HISTORY** PLEASE CHECK IF *YOU* EXPERIENCE ANY OF THE FOLLOWING

- ☐ Headaches
- ☐ Glare/light sensitivity
- ☐ Tired Eyes
- ☐ Burning
- ☐ Excessive tearing/watering
- ☐ Other __________
- ☐ Eye pain or soreness
- ☐ Irritation
- ☐ Itching
- ☐ Mucous discharge
- ☐ Sandy or gritty feeling
- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Distorted Vision (halos)
- ☐ Double Vision

**Health History** PLEASE CHECK IF *YOU* HAVE ANY OF THE FOLLOWING CONDITIONS AND INDICATE TYPE IF APPLICABLE

- ☐ Cardiovascular (heart disease, high blood pressure, stroke, etc...)
- ☐ Respiratory (asthma, emphysema, etc...)
- ☐ Gastrointestinal
- ☐ Muscles, Bones, Joints (arthritis, etc...)
- ☐ Skin (acne, skin cancer, etc...)
- ☐ Neurological (multiple sclerosis, etc...)
- ☐ Other __________
- ☐ Endocrine (diabetes, etc...)
- ☐ Blood/Lymph disorder (cholesterol, anemia, etc...)
- ☐ Immunologic (lupus, sarcoidosis, etc...)
- ☐ Pregnant or nursing
- ☐ Cancer
- ☐ Psychiatric (anxiety, depression, etc...)

**Family Health History** PLEASE CHECK IF ANY OF *YOUR IMMEDIATE FAMILY MEMBERS* (LIST WHO) HAVE ANY OF THE FOLLOWING AND INDICATE TYPE IF APPLICABLE

- ☐ Blindness or loss of vision
- ☐ Cataract (s)
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Other __________
- ☐ Retinal detachment
- ☐ Strabismus (eye turn)
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Thyroid disease
- ☐ High Cholesterol

**OPTOS RETINAL IMAGING OR DILATION OF THE EYE**

The doctor recommends either Optos Retinal Imaging or dilation ***every year*** to check the internal health of the eye.

- ❖ Optos Retinal Imaging is $39 total for both eyes.
- ❖ There is no charge for dilation if it is done today or within the next 30 days.

***PLEASE CHOOSE ONE OF THE FOLLOWING***

- ☐ I would like to have the Optos Retinal Imaging for $39
- ☐ I would like to have my eyes dilated: ☐today ☐within 30 days
- ☐ I decline both Optos Retinal Imaging and dilation

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# FINANCIAL POLICY

**Patient Name:** ______________________________ **SSN#** ________________

We are committed to meeting your health care needs. We would rather control billing costs than to be forced to raise our fees. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- All Professional services and materials are charged to the patient. The patient's portion is paid at the time services are rendered unless other arrangements are made in advance.
- You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a $75 returned check charge being added to your account.
- It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
- It is your responsibility to contact your insurance carrier to confirm that our Optometrist participates on your plan. If you see a doctor who is currently not on your plan, you will be responsible for payment in full.
- Payment from your insurance company will be paid directly to Complete Family Eyecare and Optique, P.C. We will file any secondary insurance with proof of insurance. Please understand that all benefits quoted to the undersigned are not a guarantee of payment by your insurance company and that final determination can be made only when the claim is processed.
- If your insurance plan requires a referral, it is your responsibility to obtain this referral prior to being seen by the doctor. If our office is required to obtain the referral for you, please notify our office 72 hours (3 business days) prior to the specialist visit so that we have ample time to acquire this information from your insurance company.
- If you miss your appointment you will be charged a NO SHOW fee at the rate agreed on between Complete Family Eyecare and your insurance company (an amount which your insurance company would have paid to us for the visit plus the amount of your co-pay or co-insurance) but a minimum of $70 for each appointment missed, no exceptions.
- Accounts 90 days old are subject to collection fees. You, the patient, accept responsibility for all fees incurred and agree that if it is necessary for Complete Family Eyecare to pursue collection activity on your account, either through a collection agency for an attorney, you, the client shall be responsible for all costs of such collection activity, including but not limited to, reasonable attorney's fees. Collection fees of 30% (thirty percent) will be added to the patient's account balance to cover such service fees
- All record requests must be in writing and received by our office at least 72 hours (three business days) prior to the date needed. Records over 10 pages will be mailed or emailed but not faxed.

**Patient Signature** ______________________________ **Date** ________________