VALLEY Vision & OPTICAL

Dr. Casey J. Andrus, *Optometric Physician*
& Associates

WELCOME TO OUR OFFICE!
REGISTRATION FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Birth Date: _____ Gender: **M / F**

Home Address: _____ City: _____

State: _____ Zip: _____ Which is the best telephone number to contact you? ☐ **Home** ☐ **Work** ☐ **Cell**

Home Phone: _____ Work: _____ Cell: _____

For future appointment reminders by E-mail, please provide E-mail address:_____

How did you hear about our office? ☐ **Family/Friend** ☐ **Insurance Directory** ☐ **Phone Book** ☐ **Internet Search/Website**
☐ **Other**_____

Are any family members patients at this office? **Y / N** Names:_____

Primary Care Doctor:_____ Clinic:_____

Emergency Contact (or Parent if a minor):_____ Phone:_____ Relation:_____

Are we billing insurance? **Y / N** Insured's Name (if different from patient): _____

****We require a copy of all insurance cards on the day of service***

Routine Vision Exams vs. Medical Eye Visits

Routine eye exams (well-vision eye exams) are usually part of a vision plan, which is a separate benefit from your medical insurance plan. A routine eye exam provides a screening of eye health, but assumes the eyes are healthy and only suffer from vision problems such as nearsightedness, farsightedness, etc.

Medical insurance benefits are billed if you are seeing us with a medical eye condition such as diabetes, glaucoma, cataract, dry eye, contact lens complications, irritated eyes, headaches, etc. Our office is required to follow proper coding and billing guidelines, and will submit charges for these conditions to your medical insurance since vision plans do not cover medical eye visits or testing. We cannot always determine which plan (vision or medical) should be billed until the examination is complete. Services and testing we provide for eye health conditions may be subject to additional copays or deductibles as directed by your medical insurance plan.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have had explained, been offered, received, or read a copy of Casey J. Andrus, OD, PLLC's Notice of Privacy Practices and wish to continue care under these terms. Every effort is made to protect your privacy and inform you of your rights related to your personal health information.
CONSENT FOR TREATMENT: I hereby authorize Casey J. Andrus, OD, PLLC to administer necessary diagnostic and medical procedures for proper eye care.
NO SHOW/CANCELATION POLICY: I understand there is a $65 fee for not showing or canceling a scheduled appointment with less than 24 hours' notice.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. I authorize the release of any medical or other information necessary to process this claim. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company at the time of service, and understand quotes received from the insurance company are not a guarantee of payment. I authorize insurance benefits to be paid directly to the contracted provider.

SIGNATURE (Patient or Guardian): _____ DATE: _____

CHIEF CONCERNS

Do you have any questions for the Doctor today? In this space please explain any symptoms or concerns you are experiencing.

FAMILY HISTORY

Has a parent or sibling been diagnosed with any of the following (check all that apply):

☐ **No problems** ☐ **Diabetes** Relation _____ ☐ **High blood pressure** Relation _____ ☐ **Cancer** Type_____ Relation _____

Has a parent or sibling been diagnosed with any of the following eye problems (check all that apply):

☐ **No problems** ☐ **Glaucoma** Relation _____ ☐ **Macular degeneration** Relation _____ ☐ **Retinal Detachment** Relation _____

SOCIAL HISTORY

Do you smoke? ☐ **Y** ☐ **N** If no, are you a former smoker? ☐ **Y** ☐ **N**

Do you consume alcohol? ☐ **Y** ☐ **N**

If yes, how much per week do you smoke?_____

If yes, how many drinks per week?_____

What is your occupation?_____

Who is your Employer?_____

REVIEW OF SYSTEMS

Do you have any history of the following?

Ocular/Eye Problems
- Inflammatory disorder ☐ **Y** ☐ **N**
- Surgery ☐ **Y** ☐ **N**
- Glaucoma ☐ **Y** ☐ **N**
- Amblyopia (lazy eye) ☐ **Y** ☐ **N**
- Cataract ☐ **Y** ☐ **N**
- Retinal problems ☐ **Y** ☐ **N**
- Macular degeneration ☐ **Y** ☐ **N**
- Strabismus (eye turn) ☐ **Y** ☐ **N**
- Other _____

Constitutional Problems
- Cancer :_____ ☐ **Y** ☐ **N**
- Chronic fatigue ☐ **Y** ☐ **N**
- Developmental disability ☐ **Y** ☐ **N**
- Other _____

Ears, Nose, Mouth, Throat Problems
- Dry mouth ☐ **Y** ☐ **N**
- Hearing loss ☐ **Y** ☐ **N**
- Sinusitis ☐ **Y** ☐ **N**
- Other _____

Neurological Problems
- Multiple sclerosis ☐ **Y** ☐ **N**
- Tumor ☐ **Y** ☐ **N**
- Epilepsy ☐ **Y** ☐ **N**
- Other _____

Psychiatric Problems
- Depression ☐ **Y** ☐ **N**
- Other _____

Cardiovascular Problems
- Vascular disease ☐ **Y** ☐ **N**
- Stroke ☐ **Y** ☐ **N**
- Heart disease ☐ **Y** ☐ **N**
- High blood pressure ☐ **Y** ☐ **N**
- Other _____

Respiratory Problems
- Emphysema ☐ **Y** ☐ **N**
- Asthma ☐ **Y** ☐ **N**
- COPD ☐ **Y** ☐ **N**
- Other _____

Gastrointestinal Problems
- Colitis ☐ **Y** ☐ **N**
- Crohn's disease ☐ **Y** ☐ **N**
- Ulcer ☐ **Y** ☐ **N**
- Other _____

Genitourinary Problems
- Prostate disease/cancer ☐ **Y** ☐ **N**
- STD ☐ **Y** ☐ **N**
- Kidney disease ☐ **Y** ☐ **N**
- Other _____

Musculoskelatal Problems
- Fibromyalgia ☐ **Y** ☐ **N**
- Muscular dystrophy ☐ **Y** ☐ **N**
- Osteoarthritis ☐ **Y** ☐ **N**
- Other _____

Skin Problems
- Rosacea ☐ **Y** ☐ **N**
- Eczema ☐ **Y** ☐ **N**
- Other _____

Endocrine Problems
- Diabetes ☐ **Y** ☐ **N**
- Hormonal dysfunction ☐ **Y** ☐ **N**
- Thyroid dysfunction ☐ **Y** ☐ **N**
- Other _____

Blood/Lymph Problems
- Large volume blood loss ☐ **Y** ☐ **N**
- Anemia ☐ **Y** ☐ **N**
- Other _____

Allergy/Immunologic Problems
- Environmental allergies ☐ **Y** ☐ **N**
- Rheumatoid arthritis ☐ **Y** ☐ **N**
- Lupus ☐ **Y** ☐ **N**
- Other _____

Office Use:

Reviewed by_____ Date _____

Reviewed by_____ Date _____

Reviewed by_____ Date _____

Reviewed by_____ Date _____

Reviewed by_____ Date _____

To better understand how you use your eyes and how we can improve their function, please answer the following:

Are your eyes sensitive to sunlight? ☐ **Y** ☐ **N**

Do you use a computer over 2 hours a day? ☐ **Y** ☐ **N**

Problems with reflections or glare? ☐ **Y** ☐ **N**

Interested in new contact lens materials? ☐ **Y** ☐ **N**

Want information on LASIK vision surgery? ☐ **Y** ☐ **N**

Please list your favorite sporting activities / hobbies:

_____

List any prescription medications you are currently taking (or provide a list to copy):

_____

_____

_____

_____

_____

_____

List any medicine allergies:

_____

_____

List any other allergies:

_____

_____

Welcome to Our Office

Thank you for choosing us for your eye care needs. While our goal is to make your care as friendly and convenient as possible, please acknowledge these important office policies:

I understand I am responsible for all charges not covered by my insurance company.

- Insurance benefits quoted to us are always an estimate and never a guarantee of payment.
- All co-pays, co-insurance and deductible amounts are due at the time of service.

All orders for glasses and contact lenses are final when placed and are non-refundable.

- Payment is required for glasses or contact lens orders to be placed.
- Any balance must be paid in full before orders are dispensed.
- Every effort is made to ensure you are happy with your eyewear, but they are a prescription medical device and cannot be returned for refunds.

NAME (Print) _____ DATE _____

SIGNATURE (Patient or Guardian) _____

Contact Lens Patients

To properly evaluate your vision and eye health from contact lens wear, additional tests and expertise are needed beyond the standard eye exam. There is a $75 contact lens evaluation fee to update an existing contact lens prescription. Other fees for changing lens type, design, or fitting and training new wearers with contact lenses will be discussed with you as needed.

- Your Contact Lens prescription will always be provided to you when your contact lens fitting process is complete.
- A digital copy of your Contact Lens prescription is available at any time on our patient portal, "Revolution PHR," and is automatically updated once your prescription is final.
- Paper and emailed copies are always available, but if email is requested, be aware it is not a secure method of sending personal health information and must be at your request.

I consent to receive my contact lens prescription electronically through the patient portal and have received sign-in information. If I prefer a different method of receiving my contact lens prescription, I will notify you below:

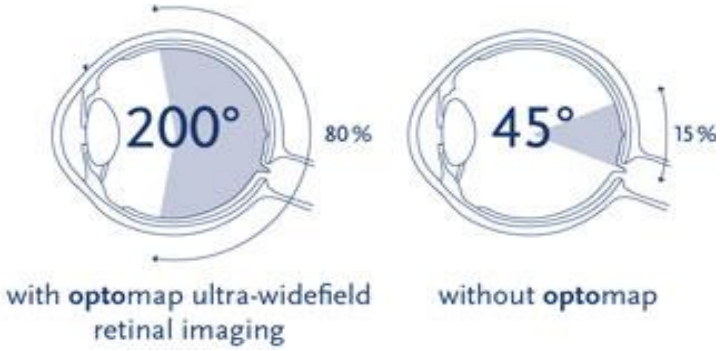
SIGNATURE (Patient or Guardian) _____ DATE _____

optomap®
Retinal Exam

We are excited to introduce a new technology, called the Optomap, which is used as part of your eye health exam to take a digital image of the back of your eye. In just seconds it will help evaluate the health of your retina, and detect many eye diseases such as diabetes, glaucoma, macular degeneration, retinal detachments and even eye cancers; many of which often start without any symptoms but can lead to vision loss.

We strongly believe that the Optomap® Retinal Exam is an essential part of your comprehensive eye exam and prescribe it for all patients each year because:

- It allows for an enlarged image to see a more detailed view of the retina in just seconds
- Allows for future comparisons--we can accurately compare each year's image side by side
- Can be reviewed by other doctors, if necessary
- It may take the place of dilation in many patients, so you leave the office with vision intact, rather than with light-sensitivity and blur



The Optomap screening has a $39 fee that insurance does not cover. The Doctor will review and discuss the images with you during your exam today.

☐ I agree to the recommended annual Optomap screening today

☐ I refuse the recommended Optomap eye health screening

_____ _____

Signature (Patient or Guardian) Date