EYE PHYSICIANS
OF LIBERTYVILLE

Patient Information

Name: _____ Date of Birth _____/_____/____
Address:_____
City:_____ State:_____ Zip: _____ Age: _____ Sex: M/F_____

Phone: Home: (___) _____Work: (___)_____ Cell: (___)_____
Email Address: _____

Employer/School (If Child, parent's information):
Occupation: _____ Name:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (___)_____

Whom may we thank for referring you : _____
Who is your Primary Care Physician :_____
What Pharmacy do you use:_____
Reason for todays Visit: _____

Insurance Information

Primary Insurance: _____
Policy Holder: _____ Date of Birth _____/_____/____
Address:_____
City:_____ State:_____ Zip: _____

Secondary Insurance: _____
Policy Holder: _____ Date of Birth _____/_____/____
Address:_____
City:_____ State:_____ Zip: _____

Are you personally responsible for the payment of your fees? Yes/ No If no, who is?
Relationship to patient: _____
Name:_____ Date of Birth _____/_____/____
Address:_____
City:_____ State:_____ Zip: _____

Health History

Name: _____ Date: _____

Do you currently have or previously been diagnosed with:

Please circle your answers

Asthma	Y	N
Rheumatoid Arthritis	Y	N
Environmental Allergies	Y	N
Diabetes	Y	N
Insulin Dependent	Y	N
If yes, how many years? _____		
High Blood Pressure	Y	N
If yes, how many years? _____		
High Cholesterol	Y	N
Cancer	Y	N
Involving Which Organs? _____		
Heart Disease	Y	N
Open Heart Surgery	Y	N
Migraines	Y	N
Kidney Disease	Y	N
Head or Spinal Injuries	Y	N
Seizures	Y	N
Temporal Arteritis	Y	N
Carotid Artery Disease	Y	N
Stroke	Y	N
Brain Tumors, non cancerous	Y	N
Aneurysm	Y	N
Thyroid Condition	Y	N
Do You Currently Smoke	Y	N
How much alcohol do you drink? _____		
Do you use any illicit drugs	Y	N

List your medications here ❑ none

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to medications ❑ none

_____

_____

_____

Any other disease or condition _____

Ocular History

Have you been diagnosed with any of the following eye diseases or conditions:

Cataracts	Y	N	Corneal Disease	Y	N
Glaucoma	Y	N	Retinal Disease	Y	N
Crossed Eye	Y	N	Iritis	Y	N
Keratoconus	Y	N	Macular Degeneration	Y	N

Any other eye diseases or injuries _____

Have you had eye surgery: Y N Which Eye(s) _____

Circle: Cataract Retina Corrective (RK/PRK/LASIK) Date of Surgery: _____

Family History

Has any blood relative had the following:

Glaucoma	Y	N	Diabetes	Y	N
Cataracts	Y	N	Heart Disease	Y	N
Corneal Disease	Y	N	High Blood Pressure	Y	N
Macular Degeneration	Y	N	Stroke	Y	N
Retinal Detachments	Y	N	Other _____		
Crossed/Lazy Eye	Y	N			

Technician Signature: _____ Date: _____

Updated _____ rev 7-13-05

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RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I am a patient of Eye Physicians of Libertyville. I hereby acknowledge that I have received, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that Eye Physicians of Libertyville has reserved the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me with a revised Notice of Privacy Practices upon my request.

I ACKNOWLEDGE AND AGREE THAT NO AMENDMENT TO THIS FORM IS PERMITTED. I MAY REQUEST AMENDMENTS TO MY MEDICAL RECORDS IN ACCORDANCE WITH STATE AND FEDERAL LAW AND REGULATION.

With this consent, Eye Physicians of Libertyville, or our agents may call my home, cell or other alternative locations and leave a message on voicemail or in person, including but not limited to, appointment reminders, billing items and any calls pertaining to my care.

_____ _____

Signature of Patient or Authorized Agent Date

Family and Friends: It is the office policy of Eye Physicians of Libertyville not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/guardians, please indicate below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names in the future please confirm this in writing).

Name [please print]: _____ Relationship_____

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EXPLANATION OF REFRACTION

Refraction is a measurement of the lens power that is required to focus your vision. It is necessary whenever you want a new pair of glasses or contact lenses. But refraction is also helpful in measuring the growth of the eyes or changes in the shape of the cornea. In addition, refraction detects diabetes, cataracts, lens changes, and sometimes, tumors of the eye.

Unfortunately, **NEARLY EVERY MEDICAL INSURANCE, INCLUDING MEDICARE, *DOES NOT COVER* THE COST OF REFRACTION.** Some vision care plans do pay for this service, but we do not directly bill vision care plans. Therefore, a refraction is part of your examination, and we ask that you pay for this separately. Our Refraction fee is $59.00

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. The insurance co-payment is separate from and not included in the Refraction fee.

_____ _____

Patient signature Date

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Appointment Cancellation, No Show, and Late Arrival Policies

We strive to provide excellent medical care to you and to all of our patients. Consistent with this, we have developed appointment cancellation and no-show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficiently uses your time.

Our Cancellation and No-Show Policy is as follows:

We request that you please give our office at least 24-hour notice in the event that you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you will be charged a $50 rescheduling fee, or you may be asked to prepay in full for your next appointment. Additionally, you may be offered limited appointment times.

A patient who is a no-show three times or more may not be rescheduled for future appointments and may be dismissed from the practice.

Our Late Arrival Policy is as follows:

If a patient is more than 15 minutes late to their appointment, the appointment may be canceled and need to be rescheduled. Patients arriving late may also be asked to wait to be seen until the provider has an opening in their schedule. If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.

I have read and understand the Eye Physicians of Libertyville Cancellation and No-Show Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I _____ (print name) have read and received a copy of Eye Physicians of Libertyville's Cancellation Policy.

_____ _____

Patient Signature Date