ARKANSAS EYE SITE

Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this history form is confidential and critical to your visual and health evaluation.

Date: _____

Patient Information

Last: _____

First: _____ MI: _____

Street: _____

City: _____

State: _____ Zip code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

SSN: _____

DOB: _____ Age: _____

Sex: M or F Marital Status: _____

Ethnicity: _____

How do you prefer we contact you?

__Home __ Work __Cell __Text __Email

Employer/School: _____

Occupation/Grade: _____

Spouse/Parent: _____

Spouse/Parent work: _____

Pharmacy: _____

Primary Care Physician: _____

Primary Insurance: _____

Member ID: _____

Group ID: _____

Card Holder Name & Date of Birth:

_____

Secondary Insurance: _____

Member ID: _____

Group ID: _____

Card Holder Name & Date of Birth:

_____

Vision Insurance: _____

Member ID: _____

Card Holder Name & Date of Birth:

_____

Card Holder SSN: _____

Are you covered under an employer or union policy?

❑ Yes ❑ No

Are you covered under any other health care plan?

❑ Yes ❑ No

Are you enrolled in a Medicare Advantage Plan?

❑ Yes ❑ No

If not referred, how did you choose our office?

❑ Friend/Relative ❑ Insurance List

❑ Another Doctor ❑ Saw Sign/Building

❑ Newspaper/Radio/TV

❑ Yellow Pages: Directory? _____

❑ Online search: Where? _____

❑ Other: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature _____ Date: _____

ARKANSAS EYE SITE

Patient Name _____

Patient Medical History Form

Please complete the following form as thoroughly as possible.
The information in this history form is confidential and critical to your visual and health evaluation.

Please List Current Medications:
(Including vitamins, birth control and over the counter medications)

- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____

Please List Eye Drops Or Eye Medications you use:

- _____ • _____
- _____ • _____

Are you ALLERGIC to any medications? Please list:

- _____ • _____
- _____ • _____

Do you use tobacco products? ❑ Yes ❑ No
Former tobacco user? ❑ Yes ❑ No
Do you drink alcohol? ❑ Yes ❑ No

Have you ever had an eye-related surgery?
❑ Yes ❑ No

If yes, please specify:
• _____

Please List All Surgical History:

- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____

Have you ever experienced, been diagnosed, or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of Light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Watering
❑ Uncomfortable Glasses
❑ Eye Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other Eye Disorders: _____

Have you ever been diagnosed with the following?

❑ Acid Reflux
❑ Allergies/Sinus
❑ Alzheimer's/Dementia
❑ Arthritis
❑ Asthma
❑ Blood/Lymph
❑ Cancer
❑ Cholesterol
❑ Crohn's/IBS
❑ COPD/Emphysema
❑ Depression/Anxiety
❑ Diabetes
❑ Eczema/Rashes
❑ Epilepsy
❑ Fibromyalgia
❑ Heart Attack
❑ Heart Disease
❑ High Blood Pressure
❑ Lupus
❑ MS
❑ Parkinson's
❑ Stroke
❑ Thyroid
❑ Other: _____

Do you have a FAMILY history of any of the following?
Check all that apply and indicate relationship.
(Deceased and Living)

❑ Cataracts _____
❑ Glaucoma _____
❑ Macular Degeneration _____
❑ Retinal Problems _____
❑ Corneal Problems _____
❑ Lazy Eye _____
❑ Diabetes _____
❑ High Blood Pressure _____
❑ Heart Disease _____
❑ Cancer _____
❑ Other: _____
❑ Other: _____

ARKANSAS EYE SITE

Patient Name: _____

Date of Birth: _____

Authorization to Release Patient Information:

I, _____, hereby authorize Arkansas Eye Site to discuss and release any medical information to the persons named below. This includes glasses/contact lens pick-ups, appointment information, and permission to contact them if unable to reach me when necessary.

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Initials: ____

Assignment of Benefits:

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverage's, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Initials: ____

Refraction Authorization:

Refraction is the process of the doctor checking your glasses or contact lens prescription. Medical insurances do not cover this charge because it is considered to be routine vision and not medically necessary.

The charge of $20.00 is due at the time of service.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

o **Option 1: YES, I want to receive these items or services.**

I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

o **Option 2: NO, I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

Signature of Patient or Legal Guardian: _____ Date: _____

Optos Retinal Imaging Information

Our Optomap technology gives your eye doctor a comprehensive view of your retina, which helps in spotting signs of diseases at their earliest stages. By viewing most of the retina at once, your eye doctor can spend more time explaining the images and discussing your eye health with you.

Optomap is recognized in numerous clinical studies as a valuable diagnostic tool. Starting January 1, 2024, we will include this technology in our regular exams as a part of our commitment to high-quality care. We take yearly photos to assist your doctor in monitoring your retinal health and to keep a digital record for future comparison.

THIS TEST IS NOT COVERED BY INSURANCE

Service Fee: $25.00

___YES, I would like to receive this service.

___NO, I would NOT like to receive this service

Patient Signature: _____

Date: _____

Lifestyle Index

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 (3 filled)

Headaches
of any severity each week, usually getting worse later in the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Stiffness / pain in neck / shoulders
when you work at a computer or read

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Discomfort with Computer Use
in your eyes (redness, burning) after long hours looking at the screen

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Tired Eyes
with increasing feeling of eye fatigue throughout the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Dry Eye Sensation
feeling progressively more gritty/sandy while working at computer or reading

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Light Sensitivity
especially with brighter, stronger lights like fluorescents or headlights

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Motion Sickness
or an experience like dizziness or vertigo

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

FOR OFFICE USE

Neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	