NVISION
EYE CENTERS

1-877-91-NVISION
1-877-916-8474
www.NVISIONCenters.com

PATIENT INFORMATION

Date: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: _____ ☐ Male ☐ Female

Phone #s: Home (____) _____ Cell (____) _____ Work (____) _____

E-Mail: _____

Social Sec. #: _____-____-_____ Employer: _____ Occupation: _____

List your hobbies or activities that require special visual needs: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

Circle one: My Eye Doctor / Past Patient / Advertisement / Internet / Workplace Event / Benefits Provider / Radio / Other

Who of the above influenced you most to schedule an appointment with us? Name: _____

Relationship: _____ Did he/she have refractive surgery? ☐ Yes ☐ No

Who is your Eye Doctor? _____ Name of Practice/Clinic: _____ City: _____

Has your Eye Doctor ever discussed Laser Vision Correction with you? ☐ Yes ☐ No

Did they refer you to NVISION? ☐ Yes ☐ No If YES, Which surgeon were you referred to? _____

If NO, who did they refer you to? _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Phone: (____) _____

May we discuss your medical records / bills/ payments with them? ☐ Yes ☐ No

VISION INSURANCE INFORMATION (medical insurance on separate page):

Circle one: VSP Spectera Vision Davis Vision Other: _____

Vision Policy Holder: _____ Relationship to Patient: _____

Social Security #/ID #: _____ Date of Birth: _____

MEDICAL HISTORY QUESTIONNAIRE

This information is strictly confidential. The answers will help determine if you are a suitable candidate. Certain health problems may indicate potential problems with healing. Please elaborate on all "yes" answers.

Who is your Primary Care Physician? _____ Phone: _____ Location: _____

List all major illnesses or injuries: _____

List any surgeries you have had: _____

List any EYE Drops/Medications you currently take AND WHAT TIME you last used them: _____

_____

List any systemic medications you currently take (**prescription and over-the-counter**): _____

_____

Do you have allergies to any medications: ☐ Yes ☐ No If **yes,** please list:

_____

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REFRACTIVE SURGERY PATIENT QUESTIONNAIRE

Name: _____

Reasons for wanting Refractive Surgery: (Check all that are applicable.)

- ☐ Job requirement
- ☐ Recreational activity (swimming, skiing, etc.)
- ☐ Cosmetic (I hate my glasses)
- ☐ Simply Fed Up
- ☐ Can't wear contact lenses
- ☐ Improved functional ability
- ☐ Reduce dependence on glasses/contacts
- ☐ Other: _____

1. Have you ever had a consult for laser vision correction before? ☐ Yes ☐ No
2. What concerns do you have about having laser vision correction? _____
3. What is important to you when choosing a center and surgeon with whom to have laser vision correction?
4. When would you be interested in having laser vision correction if you are considered a candidate?

Please rate the following for each eye **(WITH CORRECTION)**:

	RIGHT EYE					LEFT EYE				
	Absent	Mild	Moderate	Marked	Very Severe	Absent	Mild	Moderate	Marked	Very Severe
a. Light sensitivity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Redness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e. Dryness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f. Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
g. Gritty feeling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
h. Glare	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
i. Halos	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
j. Blurry vision	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
k. Ghost images	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
l. Fluctuation of vision	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
m. Difficulties with night driving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other problems: _____

Comments: _____

_____

Patient Signature: _____ Date: _____

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EYE DISORDERS:

Any eye disorders	☐ Yes ☐ No		Retinal tear or detachment	☐ Yes ☐ No	
Glaucoma (High eye pressure)	☐ Yes ☐ No		Cataract	☐ Yes ☐ No	
Dry eye syndrome	☐ Yes ☐ No		Recurrent corneal erosion	☐ Yes ☐ No	
Amblyopia ("lazy eye")	☐ Yes ☐ No		Keratoconus	☐ Yes ☐ No	
Any eye injury	☐ Yes ☐ No		Any eye dystrophy or degeneration	☐ Yes ☐ No	
Eye surgery	☐ Yes ☐ No		Any herpes infection in the eye	☐ Yes ☐ No	
ALK/RK/LASIK/PRK surgery	☐ Yes ☐ No		Other (list):	☐ Yes ☐ No	
Any infection in the eye	☐ Yes ☐ No		Explain: _____		

If you answered yes to any eye history questions above, please explain:

_____

_____

CONTACT LENS / GLASSES HISTORY:

1. In what year did you first started wearing contact lenses? _____ What type? _____
2. What kind do you wear now? _____ How many hours a day? _____
3. When did you last wear your contacts? _____
4. Any history of contact lens-related eye infections? _____ Corneal ulcers? _____
5. Please check the type of contact lenses: ☐ Soft Daily Wear ☐ Soft Extended Wear ☐ Hard Contacts ☐ Soft Toric Lenses ☐ Disposable Contacts ☐ Rigid Gas Permeable
6. Do you currently wear glasses? ☐ Yes ☐ No If **yes**, how long have you had the current prescription? _____

EYES SYMPTOMS:	Yes	No	Details
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision (Halos)			
Glare of Light Sensitivity			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Scratchy, Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing or Watering			
Eye Pain or Soreness			
Infection of Eye or Lid			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Dropping Eyelid			

OVERALL HEALTH	Yes	No	Details
General/Constitutional (Fever, Weight Loss, etc.)			
Ears, Nose, Throat (Stuffy nose, Earache, Cough, Vertigo, etc.)			
Cardiovascular (High Blood Pressure, Racing Pulse, etc.)			
Respiratory (Congestion, Wheezing, etc.)			
Gastrointestinal (Heartburn, Asthma, Wheezing, etc.)			
Genital, Kidney Bladder (Painful /frequent urination, impotence, etc.)			

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OVERALL HEALTH – continued	Yes	No	Details
Muscles, Bones, Joints (Joint pain, Stiffness, Swelling, Cramps, Arthritis, etc.)			
Skin / Integumentary (Pimples, Warts, Growths, Rashes, etc.)			
Neurological (Numbness, Headache, etc.)			
Psychiatric (Anxiety, Depression, Insomnia, Stress, etc.)			
Endocrine / Metabolic (Diabetes, Hypothyroid, etc.)			IF DIABETES: WHAT IS BLOOD SUGAR & WHEN TESTED:
Blood/Lymph (Cholesterolemia, Anemia, Bleeding, Bruising, etc.)			
Allergic / Immunologic (Sneezing, Swelling, Redness, Itching, Hives, Seasonal Allergies, etc.)			

FAMILY HISTORY: M=Mother, F=Father, S=Sister, B=Brother, MGM=Maternal Grandmother, MGF=Maternal Grandfather PGM=Paternal Grandmother, PGF=Paternal Grandfather

Disease	Yes	No	Relationship to Patient
Arthritis			
Blindness			
Cancer			
Diabetes			
Glaucoma			
Heart Diseases or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No If **yes:** Occasional 1 per day 2-3 per day 4+ per day

Do you drink caffeine? ☐ Yes ☐ No If **yes:** _____ cups per day

Do you smoke / use Tabaco? ☐ Yes ☐ No If **yes:** Occasional ½ pack/day 1 pack/day 1+ pack/day

Have you ever smoked? ☐ Yes ☐ No If **yes:** How long ago? _____

Have you ever tried to quit? ☐ Yes ☐ No If **yes:** How long ago? _____

Are you exposed to second hand smoke? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

PREFERRED PHARMACY INFORMATION:

Name: _____ Street Address: _____

Cross Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

By Signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

_____
Name of Patient (Please print)

_____ _____
Signature of Patient Date

Are you completing this form for someone else?

☐ Check here if you are signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you are acting on that person's behalf (for example, power of attorney)

_____ _____
Signature Date

_____ _____
Print Name Relationship

References Available on the Internet:
www.hospitalconnect.com/aha/about/pbillofrights.html
www.isrs.org
Other References:
Internal Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Pre-operative and Post-operative Care, 2001 available form www.isrs.org

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the:

Medical Board of California www.mbc.ca.gov
Oregon Medical Board www.oregon.gov/OMB
Nevada State Board of Medical Examiners www.medboard.nv.gov

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PAYMENT POLICY

Basic Policy:
Payment for service is due in full at the time service is provided in our office.

Patients with Insurance:

LASIK/REFRACTIVE SURGERY IS NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS
Some treatments are billable to insurance, while others are not. NVISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your NVISION provider is not contracted with your carrier, payment may be due in full at the time of service. If we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and NVISION will supply you with the necessary information to do so. NVISION does not guarantee that your insurance provider will reimburse for services rendered. NVISION is not responsible for denied insurance claims.

We will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services will be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

Non-covered Services:
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Assignments of Insurance Benefits:
I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand I am financially responsible to NVISION for the charges incurred.

Have you met your deductible for the calendar year?

☐ Yes ☐ No ☐ Not Sure

(Circle Y or N)

Are you currently employed?	Y	N	Are you covered under an employer or union policy?	Y	N
Are your injuries accident related?	Y	N	Is your spouse or other family member employed?	Y	N
Did you sustain an injury at work?	Y	N	Do you have a secondary insurance policy?	Y	N
Have you ever served in the military?	Y	N	Are you covered under any other healthcare plan?	Y	N

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

Patient Name (Print): _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____