

Dear Valued Patient:

Welcome to Heights Eyecare and Vision Performance Specialties. Thank you for entrusting us with providing the best vision care possible to you and your family.

We ask that you please do the following in preparation for your evaluations:

- ❑ Bring with you the enclosed “Welcome to the Office,” patient information form. This will ensure we address all your vision care needs and answer all of your questions.
- ❑ The OPTOMAP takes a high resolution, 200 degree wide, color digital image of the retina. Your doctor does recommend this advance technology, as it will enable them to immediately review the retinal images with you. It provides a comprehensive health assessment of the retina for a minimal fee of \$30.
- ❑ Bring a list of all medications you are currently taking for the doctor to review.
- ❑ If you wear glasses or sunglasses bring them with you so that your doctor can verify them and make recommendations for updating them as necessary.
- ❑ If you are a current contact lens wearer (even part-time), wear the contact lenses to the appointment. Your doctor will perform a cornea and contact lens analysis to assess their performance and effect on the health of your eyes and best visual acuity. Also, bring the empty box or wrapper of the current contacts you are wearing to allow the doctor to determine the exact brand and fit of your current contact lenses.

Heights Eyecare Financial Policy

Drs. Linde, Kimball, Hill, and Dull along with the staff are pleased that you have chosen us for your eye care needs. We would like to make you aware of our financial policy and appreciate your cooperation. Please review and sign.

EXAMINATION/TREATMENT- Payment in full is due at the time of service.

PRODUCT (contacts, glasses, etc.)- Payment in full is due at the time of order.

BILLING INSURANCE- We will gladly bill your insurance but you are ultimately responsible for all charges not paid for by your insurance company. There are circumstances in which we are not a participating provider for the insurance company. In this instance, payment in full is expected at time of service/order. Along with your paid receipt, we will provide you with the necessary information for you to submit the insurance yourself, with direct reimbursement to you.

CO-PAYMENT- The patient share of the bill is due at the time of service/order.

FLEX/CAFETERIA PLANS- Payment in full is due at the time of service. We will provide a paid receipt for direct reimbursement to you.

We accept cash, checks, debit cards, MasterCard, Visa, and Discover, and Care Credit.

I acknowledge that I am responsible to pay for all charges for treatment/services administered by Heights Eyecare. I understand and agree to the above terms of payment. I understand that if I fail to make my payments my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued due to my delinquent account.

Signature

Date

Acknowledgement of Privacy Practices

I acknowledge that I have been informed of Heights Eyecare Inc.'s Notice of Privacy Practices, and a copy of such has been made available to me.

Patient name: _____

Signature: _____ Date: _____

OPTOMAP Consent

(Circle One)

I, (elect / decline) the OPTOMAP _____ (initial/date)

Do you have problems with night vision? Yes No
 If you currently wear eyeglasses, are there certain times when you would rather not? Yes No
 (e.g. sports, business presentations, social occasions, etc.)
 Do your sunglasses have UV (ultra-violet) protection? Yes No
 Are your sunglasses your current prescription? Yes No
 Are you interested in thinner/lighter lenses? Yes No

Are there any specific times you have trouble with glasses? Contact lens? For example, sewing, reading music, fly-fishing (tying flies), shooting, etc. _____

CONTACT LENS HISTORY

Do you currently wear contact lenses? Yes No
 Are you interested in contact lenses? Yes No
 Have you ever tried to wear contact lenses? Yes No Reason for stopping _____
 If you currently wear contact lenses, does your back up eyeglasses have your correct prescription? Yes No

Would you like to be evaluated for refractive surgery today? Yes No

In order to assist the doctor in evaluating visual skills needed in the learning environment, please grade and then answer the following questions. 1 - below average 2 - average 3 - advanced

Reading ____ Spelling ____ Penmanship ____ Math ____ Writing ____ Physical Ed ____
 Does your child's school performance reflect their ability? Yes No
 Does your child struggle in reading? Yes No
 Are you happy with your child's grades in school? Yes No

REVIEW OF SYSTEMS:

Do you or family members have the following?

	YOU	FAMILY	If YES, please explain:
General/Constitutional (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears, Nose, Throat (sinus, ear infection, cough dry mouth, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular (heart, blood pressure, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory (Asthma, Emphysema, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal (ulcer, intestinal disease, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Genital, Kidney, Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscles, Bones, Joints (Arthritis, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin (Acne, warts, skin CA, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological (Multiple Sclerosis, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric (Anxiety, depression, insomnia, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine (Diabetes, thyroid, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood/Lymph (Cholesterol, anemia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergic/Immunology	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SOCIAL HISTORY: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my social history information directly with my doctor.

Do you drink alcohol? No Occasionally 1/day 2-3/day 4+/day
 Do you smoke? No Quit 1 pack/day 1+packs/day

HOBBIES/ACTIVITIES:

Computers Golf Music Fishing Biking
 Hunting Skiing Racquetball Reading Crafts/Sewing

PATIENT EDUCATION

Would you like to discuss or receive any information on our other available services? Please check all that apply.

Pediatric Vision Care Vision Therapy Dry Eye Therapy Low Vision
Specialty Contact Lens Sports Glasses Safety Glasses Frame & Lens Warranty

Date Reviewed	Reviewed By	Date Reviewed	Reviewed By:
	Tech: Dr:		Tech: Dr:

WELCOME TO OUR OFFICE

HEIGHTS EYECARE

Many insurance companies now require a complete medical history as a part of your eye examination.
Please provide as much of the following information as possible. Thank you for your time.

Name: _____ Date: _____
 Address: _____ State: _____ Zip: _____
 Home Phone: () _____ Work Phone: () _____
 Occupation: _____ E-mail: _____
 Birthday: _____ Social Security: _____ Last Eye Exam: _____
 Emergency Contact: _____ Relationship to Patient: _____ Phone: () _____

How did you hear about our office?

- Friend or Family member: _____ Insurance Company Television
 Healthcare Provider: _____ Received Mailing Newspaper
 Other: _____ Internet Yellow Pages

VISION INSURANCE INFO.	MEDICAL INSURANCE INFO.
Ins. Co. Name:	Ins. Co. Name:
Insured's Name:	Insured's Name:
Address:	Address:
Identification Number:	Identification Number:
Group:	Group:
Insured's DOB:	Insured's DOB:
Insured's SS#:	Insured's SS#:
Patient Relation to Insured:	Patient Relation to Insured:

Do you have secondary vision or medical insurance? YES NO If yes, please specify to the front desk.

MEDICAL HISTORY:

Do you have any **ALLERGIES** to medications? YES NO If yes, please explain: _____
 List any **MEDICATIONS** you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

EYE HEALTH: Do you experience any of the following?

Distance vision blur	<input type="checkbox"/> yes <input type="checkbox"/> no	Flashes of light	<input type="checkbox"/> yes <input type="checkbox"/> no	Dry Eyes	<input type="checkbox"/> yes <input type="checkbox"/> no
Near vision blur	<input type="checkbox"/> yes <input type="checkbox"/> no	Spots	<input type="checkbox"/> yes <input type="checkbox"/> no	Itching	<input type="checkbox"/> yes <input type="checkbox"/> no
Middle vision blur	<input type="checkbox"/> yes <input type="checkbox"/> no	Distorted vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Burning	<input type="checkbox"/> yes <input type="checkbox"/> no
Eye pain/soreness	<input type="checkbox"/> yes <input type="checkbox"/> no	Glare	<input type="checkbox"/> yes <input type="checkbox"/> no	Red Eyes	<input type="checkbox"/> yes <input type="checkbox"/> no
Loss of side vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Mucous	<input type="checkbox"/> yes <input type="checkbox"/> no
Light sensitivity	<input type="checkbox"/> yes <input type="checkbox"/> no	Double vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Crossed Eyes	<input type="checkbox"/> yes <input type="checkbox"/> no

EYE HISTORY	YOU	FAMILY	EXPLAIN	NOTES
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eye Injury/Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear glasses? Yes No Full time Part Time Distance Near

Glasses owned: Single vision Bifocals Safety Glasses Backup Glasses
 Progressive Trifocals Sports Glasses Sunglasses

Computers used: Yes No Hours per day: _____ Distance from computer: _____