Name:
DOB:
Chart:
Age:
Date:

His Vision Eye Care
9110 S. Sheridan Road
Tulsa, OK 74133

Stephen W. Groves, M.D.
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Comprehensive Family Eye Care
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Welcome to His Vision Eye Care

We know these forms are a nuisance, and we wish we could live without them. We have tried to streamline this to gather only the information we really need. Thanks for your assistance.

PATIENT	Patient Last Name	Patient First Name	Patient Middle Name	Today's Date
	Patient Date of Birth	Patient's Age	Patient's Gender	Primary Care Dr/Clinic (will receive copy of exam)
	Patient Street Address	City	State	Zip
	Patient is: ○ Biological child ○ Grandchild ○ Adopted child ○ Foster child ○ Other_____	Patient lives with: ○ Father ○ Mother ○ Other _____	e-mail Address	Home Phone
FATHER	Father's Last Name ○ Same as patient	Father's First Name	Father's Date of Birth	Father's Home Phone ○ Same as patient
	Father's Home Street Address ○ Same as patient	City	State	Zip
	Father's Occupation	Father's Employer	Father's Work Phone	Father's Cell Phone
MOTHER	Mother's Last Name ○ Same as patient	Mother's First Name	Mother's Date of Birth	Mother's Home Phone ○ Same as patient
	Mother's Home Street Address ○ Same as patient	City	State	Zip
	Mother's Occupation ○ Stay-At-Home Mom	Mother's Employer	Mother's Work Phone	Mother's Cell Phone
INSURANCE	PRIMARY INSURANCE	Policy Holder Name	Policy Holder Relationship	Policy Holder DOB
		Insurance Company Name	ID# for Primary Insurance	
	SECONDARY INSURANCE (If Any)	Policy Holder Name	Policy Holder Relationship	Policy Holder DOB
		Insurance Company Name	ID# for Secondary Insurance	
	INSURANCE AUTHORIZATION AND ASSIGNMENT	I hereby authorize His Vision Eye Care to furnish insurance carrier information concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by my insurance. Dr. Groves is a medical doctor of the eyes providing medical eye care. Depending on the diagnosis, your medical insurance may or may not consider this exam a covered benefit. Signed: Date:		
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES		A detailed description of your rights and how your protected health information may be used is printed in the Notice of Privacy Practices and posted in the office. I acknowledge that a copy has been made available to me. Signed: Date:		

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Patient Name:		Date of Birth:
FAMILY HISTORY	Amblyopia (lazy eye)?	Yes No (Please circle yes or no and explain all yes responses)
	Misaligned Eyes?	Yes No
	Genetic Disorders?	Yes No
	Any hereditary diseases/eye conditions?	Yes No

BIRTH, PRENATAL, DEVELOPMENTAL HISTORY	Prenatal Complications?	Yes No
	Baby Premature?	Yes No
	Birth Weight?	_____ pounds _____ ounces
	Developmental Problems?	Yes No
	Any school/learning difficulties?	Yes No

REVIEW OF SYSTEMS, MEDICATIONS, AND SURGERIES	Fever, unexplained weight loss?	Normal Abnormal
	Ears/nose/throat? (frequent ear infections, sinus trouble, etc.)	Normal Abnormal
	Endocrine? (diabetes, growth hormone deficiency, etc.)	Normal Abnormal
	Heart?	Normal Abnormal
	Lungs? (asthma, etc.)	Normal Abnormal
	Gastro-intestinal? (nausea/vomiting/diarrhea, etc.)	Normal Abnormal
	Skin?	Normal Abnormal
	Kidney/reproductive?	Normal Abnormal
	Behavioral, ADHD?	Normal Abnormal
	Neurological (cerebral palsy, developmental delay, etc.)?	Normal Abnormal
	Psychiatric?	Normal Abnormal
	Seasonal allergies?	Normal Abnormal
	Does your child take any medications daily? (Please list)	Yes No
	Are there medications which make your child sick? (Names)	Yes No
	Any surgical procedures? (Please list)	Yes No

Signed: Date:

OFFICE USE ONLY: Date:

Reviewed by:

Name:
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Chart:
Age:
Date:

His Vision Eye Care - Pediatric Patients

Welcome to our office ☺ Please help us serve your better by understanding two billing details:

1. REFRACTION CHARGE OF $25

As part of evaluating your child's eyes, a refraction needs to be performed. This is the part of the exam determining whether your child needs glasses or not, and assessing the current prescription. Typically performed annually, although in children under three years, it is often needed more than once a year.

Both private insurance (e.g. BlueCross, Aetna, etc.) and SoonerCare (Medicaid) consider this a separate billable procedure and not a part of the evaluation. The fee for the refraction is $25. Most private insurance companies DO NOT pay for the refraction. SoonerCare DOES pay for the refraction.

The fee for refraction will be collected at the time of check out. This is in addition to the co-pay for the medical services (evaluation & management). This fee is similar to the separate payment at your pediatrician for the child's immunizations or lab tests.

2. VISION VS. MEDICAL DIAGNOSIS

If the child is simply out of focus, a vision diagnosis may be present.

If the child has eye muscle problems, droopy eyelid, tear duct problems, cataracts, retinal or optic nerve problems, a medical diagnosis exists.
The doctor has no way of knowing whether your child's diagnosis will be a vision or medical diagnosis until the entire exam is complete.

Unfortunately, most private medical insurance providers DO NOT Pay for a routine vision diagnosis.

Many of our patients are referred by a pediatrician or school due to a failed vision screening.
Until the exam is finished, we do not know whether your insurance will pay for the visit.

We do offer a cash discount price in the event insurance does not pay. This is $150 for a new patient, $120 for a return patient, due on the day of service. If you are paying the cash price on the day of service, the refraction fee will be waived.

Please feel free to discuss the above with our office manager prior to being seen if you have questions.

I have read and understand the above.

_____ Patient/Legal Guardian Initials