Name:
DOB:
Chart:
Age:
Date:

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

Stephen W. Groves, M.D.
Blake Carlisle, O.D.

Comprehensive Family Eye Care
Phone 918.388.3949
FAX 918.388.0843

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 Doctor & Clinic	
Street Address	City	State	Zip	
Occupation	Employer	Cell Phone	Daytime Phone	
Email address		When was your last eye Exam? With Whom?		
Spouse's Last Name	Spouse's First Name	Spouse's Date of Birth	Spouse's Phone	
Please list any family members that are patients of our practice:				

PERSON RESPONSIBLE FOR BILL (If other than patient)			
Last Name	First Name	Relationship	Date of Birth
Street Address	City	State	Zip
Email address		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 to insurance carriers 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. We provide medical eye care. Depending on the diagnosis of your condition, 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. I have been provided with a copy of the Notice of Privacy Practices. Signed: Date:		

Name:
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Patient Name: Date of Birth:

FAMILY HISTORY		Please circle yes or no and explain all yes responses
	Amblyopia (lazy eye)?	Yes No
	Macular Degeneration	Yes No
	Glaucoma	Yes No
	Any hereditary disease/eye conditions?	Yes No
	Cataract	Yes No
	Retinal Detachment	Yes No

SOCIAL HISTORY		
	Do you now use or have used Tobacco	Yes No
	If so, # Packs / Day _________________________	Quit Yes No
	Do you now use Alcohol	Yes No
	If so, how much/often ________________________	Quit Yes No
	Current occupation	

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	Normal Abnormal
	Neurological (cerebral palsy, developmental delay, etc.)?	Normal Abnormal
	Psychiatric?	Normal Abnormal
	Seasonal allergies?	Normal Abnormal
	Any surgical procedures? (Please list)	Yes No
	Please list all current medications:	
	Please list any drug allergies:	

Signed: Date:

OFFICE USE ONLY: Date:

Reviewed by:

Name:
DOB:
Chart:
Age:
Date:

His Vision Eye Care - Adult Patients

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

1. REFRACTION CHARGE OF $25

As part of evaluating your eyes, a refraction will need to be performed. This is the part of the exam determining whether you need glasses or not, and assessing the current prescription.

Private insurance companies (e.g. BlueCross, Aetna, etc.) consider this a separate billable procedure and not a part of the evaluation. The fee for refraction is $25. Most private insurance companies DO NOT 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 primary care physician's office for immunizations or lab tests.

2. VISION VS. MEDICAL DIAGNOSIS

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

If the patient has eye muscle problems, diabetes, droopy eyelids, tearing problems, cataracts, retinal or optic nerve problems, a medical diagnosis exists.
The doctor has no way of knowing whether your 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.

We do offer a cash discount price in the event insurance does not pay. This is $165 for a new adult patient, $135 for a return adult 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's Initials