



Welcome to Wise Vision Care

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

1 - PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

Phone # (s) _____

Email _____

Sex M F Age _____ Birthdate _____

Married Single Divorced Separated Widowed

Patient Soc. Sec.# _____

D.L.# or I.D.# _____

Occupation _____
(or school -if student)

Employer _____

Work Phone # _____

Hobbies / Interests _____

Spouse's/Gaurdian's Name (Circle One) _____

How did you hear about Wise Vision Care?

Phone Book Television Newspaper Magazine

Internet Sign Insurance List

Personal Referral (who?)

Other _____

2 - INSURANCE INFORMATION

Name of Account Holder _____

Relationship to Patient _____

Medicaid Medicare Tricare Prime

BCBS name of policy _____

Other Plan _____

Group / ID # _____

Additional / Supplemental Policies _____

Group / ID # _____

Account Holder Soc. Sec. # (If different from ID #) _____

Account Holder Birthdate _____

I, the undersigned certify that I (or for my dependent) have insurance coverage with the group(s) specified above and assign directly to Drs. Warren and / or Farah Wise all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Wise to release all information necessary to secure the payment of benefits. I have been given a copy of the Wise Vision Care Notice of Privacy Practices.

Responsible Party Signature _____

Relationship _____ Date _____

3 - EYE HEALTH HISTORY

Date of last eye exam _____

Doctor's name _____

Glasses History: never worn for distance (e.g. driving, TV) only

for near (e.g. reading, computer) only full time wear

How old is your current prescription? _____

Contact Lens History: never worn soft disposable

hard / RGP specialty lens _____

How many years in contact lenses? _____

Do you sleep in your contacts? never occasionally often

What brand(s) / type(s) do you wear (E.G. Airoptix, Acuvue Oasys, etc)? _____

Do you wear toric contacts for astigmatism? Yes No Not sure

Describe any problems you have had with your contacts: _____

What is your main purpose for today's visit?

exam for glasses prescription exam for contact lens prescription

exam for laser surgery evaluation exam for "pink eye" / infection

other reason: _____

Mark on "Yes" or "No" if you currently have any of the following:

bloodshot eyes	<input type="checkbox"/> yes <input type="checkbox"/> no	eye injury	<input type="checkbox"/> yes <input type="checkbox"/> no
blur at distance	<input type="checkbox"/> yes <input type="checkbox"/> no	eye strain	<input type="checkbox"/> yes <input type="checkbox"/> no
blur at near	<input type="checkbox"/> yes <input type="checkbox"/> no	floaters / spots	<input type="checkbox"/> yes <input type="checkbox"/> no
burning eyes	<input type="checkbox"/> yes <input type="checkbox"/> no	glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no
cataracts	<input type="checkbox"/> yes <input type="checkbox"/> no	headaches	<input type="checkbox"/> yes <input type="checkbox"/> no
dim vision	<input type="checkbox"/> yes <input type="checkbox"/> no	itchy eyes	<input type="checkbox"/> yes <input type="checkbox"/> no
discharge (eyes)	<input type="checkbox"/> yes <input type="checkbox"/> no	light sensitivity	<input type="checkbox"/> yes <input type="checkbox"/> no
dizzy spells	<input type="checkbox"/> yes <input type="checkbox"/> no	seeing flashes	<input type="checkbox"/> yes <input type="checkbox"/> no
dry eyes	<input type="checkbox"/> yes <input type="checkbox"/> no	twitching eyelid	<input type="checkbox"/> yes <input type="checkbox"/> no
eye infection	<input type="checkbox"/> yes <input type="checkbox"/> no	watery eyes	<input type="checkbox"/> yes <input type="checkbox"/> no

4 - HEALTH HISTORY

Primary Doctor's Name(s): _____ Date of last visit? _____

Mark on "Yes" or "No" if you have, or a blood relative has had, any of the following problems:

	Yourself	Family Members		Yourself	Family Members
AIDS / HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Hay Fever	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart Condition	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis (Type ____)	<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	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<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
Cataracts	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Lupus	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Migraine Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Chemical Dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Retinal Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Depression	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Condition	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Eye Surgery	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Turned Eye	<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	Major Surgery	<input type="checkbox"/> yes <input type="checkbox"/> no	Describe _____
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you smoke? <input type="checkbox"/> yes <input type="checkbox"/> no		Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no	

Any health conditions other than those listed above? _____

5 - MEDICATIONS

List all medications you are currently taking, including eye drops. Also, include over-the-counter medications as well as prescription medications:

Pharmacy Name _____

Phone Number _____

7 - DILATION ACCEPTANCE / REFUSAL

Dilated fundus examinations involve the use of eyedrops which allow a more thorough evaluation of the internal eye. Refusal of dilated fundus examinations may result in inability to detect potentially sight- or life-threatening diseases. Side-effects of the eyedrops used in this procedure may hamper your ability to focus and cause sensitivity to light for several hours. In some cases, a dilation may be necessary to obtain an accurate glasses prescription.

- I wish to be dilated at the comprehensive eye exam (or whenever the doctor deems necessary).
- I do not wish to be dilated at any eye exam.
- I would like to discuss the procedure with the doctor.

Signature of Patient (or legal guardian) _____ Date _____

6 - ALLERGIES

List all known allergies to medications or other substances:

8 - MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Warren and/or Farah Wise for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____ Date _____

WISE VISION CARE, LLC
Financial Policy
1270 Ribaut Rd., Beaufort, SC 29902
843.525.947

PATIENT FINANCIAL RESPONSIBILITY

Our objective is to provide you with the highest quality health care in the most cost-effective manner; however, the ability of Wise Vision Care, LLC to achieve this objective depends greatly on your understanding of our financial policy. If you have medical insurance, we will file an insurance claim form on your behalf. Although we file your insurance claims for you, we need your active participation in this process.

MEDICARE PATIENTS – as a participating provider of Medicare Part B (physician services), Wise Vision Care LLC will file your claim with Medicare. However you are responsible for any and all coinsurance, copays, deductibles, and any services rendered not covered by Medicare.

NOTE: You will be given an Advance Beneficiary Notice of Noncoverage (ABN) form to sign in case a performed service is not covered by Medicare. Your signature on the appropriate Medicare waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility. If you have Medicare Part A only, our physician services provided at Wise Vision Care, LLC will not be covered by Medicare.

HMO/PPO/MANAGED CARE INSURANCE PATIENTS - many plans require that you obtain an authorization in order to receive care from a specialist. It is your responsibility to obtain this authorization/referral if required. Unauthorized services will be the financial responsibility of the patient. Please have your authorization/referral forms and membership card available when you check in. You will be required to pay the copay for services at time of service.

PATIENTS WITH NO INSURANCE –patients with no insurance are required to pay for the office/provider portion of their visit in full at time of service. If special financial arrangements are deemed necessary, please ask our Financial Specialist, Genevieve Legge for further assistance. It is imperative you follow these instructions immediately to satisfy your financial responsibility with Wise Vision Care, LLC.

Print Name: Patient

Relationship to Patient

Signature: Patient/Guarantor

Date