Dr. Kunle Oluwadare
Dr. Rajan Thomas

PATIENT INFORMATION FORM

LAST NAME		FIRST		M.I.		D.O.B.	/ /	AGE		SEX	M F
ADDRESS		CITY		STATE		ZIP					
CELL PHONE:		ALTERNATE #		EMAIL:							
SOCIAL SECURITY #		WHOM CAN WE THANK FOR REFERRING YOU?									

EYE HISTORY

What is the reason for your visit today? (Check one)			
1.Annual Eye Exam		Last exam date:	
2.Contact Lens Exam			
3.Medical Issue		Explain:	
4.Other			
Any prior eye injury or surgery?	Y N	Date:	
Nature of injury or surgery:			

Contact Lenses:	Wear currently		Previously		Interested	
Brand of contacts worn:						
Current eye medications and/or eye drops:						

CURRENT SYMPTOMS (check all that apply)

Symptom		Symptom	
Dry Eyes		Excessive tearing	
Itchy Eyes		Double Vision	
Red Eye		Flashing Lights	
Halos		Light Sensitivity	
Eyes Burning		Floaters in vison	
Eye Fatigue		Loss of Vision	
G.I. Distress		Joint Distress	
Poor/blurred/fluctuating vision		Muscle Fatigue	
Dry Mouth (difficulty eating crackers without water)			
Numbness in extremities (arms/legs)			

MEDICAL HISTORY

Name of Physician	
Current Medications	
Allergies to medicines: Y N (specify medicines)	
Do you use any of the following: (circle)	
Cigarettes Tobacco Alcohol Illegal Drugs	
Frequency:	

Have you been diagnosed / treated for conditions relating to: (circle Y or N)					
Allergies	Y	N	Cancer	Y	N
Arthritis	Y	N	Cholesterol	Y	N
Blood / Anemia	Y	N	Diabetes / Thyroid	Y	N
Respiratory problems	Y	N	Digestive	Y	N
Skin / Rashes	Y	N	Ear / Nose / Throat	Y	N
Urinary Problems	Y	N	Cardiovascular	Y	N
Bone / Muscle	Y	N	Psychological	Y	N
Neurological	Y	N	Currently Pregnant	Y	N
Please explain if yes:					

FAMILY MEDICAL / EYE HISTORY

Circle Y or N next to any that apply			Self / Family Member
Blindness	Y	N	
Cataracts	Y	N	
Glaucoma	Y	N	
Heart Disease	Y	N	
Macular Degeneration	Y	N	
Retinal Disease	Y	N	
"Lazy Eye"	Y	N	
Retinal Detachment	Y	N	
Sjogren's Syndrome	Y	N	
Lupus	Y	N	
Rheumatoid Arthritis	Y	N	
Diabetes*	Y	N	
*If self, what was your last blood glucose reading?			
What is your average glucose reading?			
Hemoglobin A1C #			

NOTE: Contact Lenses require additional evaluation
A separate fee will be charged for the contact lens fitting / evaluation in addition to the eye exam

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) requires that Victory Eye Care make every effort to ensure that you are informed of your rights related to your Personal Health Information (PHI) collected at our practice.

By signing below, I acknowledge that:

☐ I was given the opportunity to read, or have explained to me, prior to any services offered, Victory Eye Care's Notice of Privacy Practices (NPP) and agree to continue my care with Victory Eye Care under the terms stated within. I understand I can also review the NPP online at www.victoryeyecare.com

☐ I do not wish to continue my care with Victory Eye Care after being given the opportunity to read, or have explained to me, prior to any services offered, Victory Eye Care's Notice of Privacy Practices (NPP).

Associate Use Only:

☐ Due to the emergency nature of the Patient's care, the Notice of Privacy Practice could not be read prior to services being offered.

Victory Eye Care Associate Name (print) ____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient name ____ Signature _____________________________ Date ___________

If signing as a personal representative of the Patient, please indicate your relationship:

Representative name ____________________________________ Relationship to Patient ________________________________

ABOUT YOUR INSURANCE

There are two types of health insurance that may provide benefits that will help pay for your eye care services and products.
Our practice accepts plans from many providers for both vision and medical.

Vision Care Plans – such as VSP, EyeMed, and Davis Vision. **Medical Insurance** – such as Blue Cross/Blue Shield and Medicare

Subscriber Name	Subscriber DOB	Vision Care Plan	I.D. #	
Relationship to Patient	Medical Group#	Medical Insurance Plan	I.D. #/ SS#	
Subscriber Address		City	State	Zip Code

Vision Care Plans have benefits that cover regular eye exams as well as eyeglasses or contact lenses. Your vision care plan may also cover a basic screening for eye diseases or conditions. ***They do not cover diagnosis, management or treatment of eye diseases.***

Medical Insurance must be used for ocular complications caused by diagnosed or systemic health problems. Your doctor will determine if these conditions apply to you, but certain conditions may be considered by case history.

If you have both types of insurance plans, it may be necessary for us to bill some services to your Vision Care Plan and others to your Medical Insurance. Occasionally, this will even result in you scheduling a separate appointment to care for certain conditions. We will use coordination of benefits to minimize your out of pocket expense. All deductibles and fee amounts not covered by your insurance are due at the time of treatment.
Professional services are rendered and charged to you, not your insurance company. Please understand that any insurance contract is between you and your insurance company. Payment for services and materials are your responsibility. Our office will not enter into a dispute with your insurance company over your claim(s). This will be your responsibility and obligation.

We will bill your insurance plan for services if we are a participating provider for your plan. If some services are not paid by your plan, you will be responsible for the balance and we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract. If at the end of 60 days from date of service, your insurance company has not paid, you will be held responsible for the entire balance. Upon request, we will supply you a copy of the claim so that you can re-submit if necessary. In order to honor your insurance benefits, you must provide insurance information (i.e.: insurance cards, benefits book, etc.) We must be able to verify the current benefits available.
Agreement and Release: I, the undersigned, certify that I (or my dependent) have coverage with the insurance provider listed above. I assign all insurance benefits directly to Victory Eye Care, LLC. Further, despite my insurance coverage, I understand that I am responsible for all charges incurred. I authorize the use of this signature on all insurance submissions.

____ ______________________________

Patient signature (or parent if minor) Date

LIFESTYLE QUESTIONS			
Please take a few moments to answer some questions about how you use your eyewear. This will help us to customize recommendations for eyewear that benefit you and your visual needs. During your visit, we will refer to these notes and ask clarifying questions to make sure we understand your needs.			
1. How many pairs of eyeglasses/sunglasses do you currently use?			QTY:
List uses for each pair:	**Use** **(driving, computer, reading, etc.)**	**What do you like about this pair?**	**What do you dislike about this pair?**
2. What is your occupation?			
3. How many hours per day are you on a computer, at work and at home?			
4. How do you protect your eyes when you are exposed to sunlight? **(driving, outdoor activities, etc.)**			
5. What specific tasks do you do that require eyeglasses? (reading, sewing, etc.)			
6. Circle each symptom that describes your eyes at the end of the day:			
red itchy watery blurry strained headaches pulling other ________________			
7. Do you also wear contact lenses? If not, have your tried contact lenses?		**YES NO**	**YES NO**
8. If you wear contact lenses, how many days per week do you wear your glasses?			
9. Are you bothered by the glare of oncoming headlights?			**YES NO**
10. What else should we know about your eye care and eyewear needs?			

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Did you know that many ocular conditions/diseases can result in vision loss that is undetectable without additional visual testing?

At Victory Eye Care we offer optional diagnostic testing that will provide a more comprehensive evaluation of your eye health and allow our Doctors to follow any changes during each annual eye exam.

These tests are recommended for Patients with the following symptoms, conditions, or family history:

- **Headaches**
- **Sudden or Unexplained Vision Loss**
- **Flashing Lights**
- **Diabetes**
- **Retinal Disease**
- **High Blood Pressure**
- **Medication Side Effects**
- **Family History of Glaucoma**
- **Family History of Macular Degeneration**

Diagnostic testing is not usually covered by insurance. For this reason, Victory Eye Care charges a minimal fee for each test that is due at the time of service.

Primary Level Diagnostic Testing - $20.00

Matrix Visual Field

The Matrix Visual Field utilizes the latest generation of visual field technology to digitally measure all fields of your vision by mapping the visual pathway from the eye to the brain. This testing can detect signs/symptoms of multiple conditions such as tumors, glaucoma, retinal detachments, etc. at the earliest possible point. The earlier the diagnosis, the more neural tissue is preserved and the better the visual outcome allowed by early treatment.

MATRIX VISUAL FIELD SCREENING-$20 ACCEPT / DECLINE ___________ ___________

INITIALS DATE

Enhanced Level Diagnostic Testing - $49.00

i Wellness Screening

The i Wellness Screening combines the latest technology in retinal imaging and the OCT laser scan to capture higher detailed images than previous technology. The Doctor can now visualize 10 layers of the retina and below using technology similar to an MRI, but with greater detail. Conditions such as Age-related Macular Degeneration, Glaucoma, and Diabetic Retinopathy can often be detected earlier allowing treatment prior to vision loss.

iWELLNESS IMAGING SCREENING-$49 ACCEPT / DECLINE ___________ ___________

INITIALS *DATE*