Welcome to Northwest Vision Clinic

Patient's Name: _____ Date of birth: ____ /____ /_____ ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic or Latino Language: ☐ English Height _____
☐ Native American or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other Weight _____lbs

Phone: ( )_____-_____ Cell: ( )_____-_____ Work: ( )_____-_____ Email: _____

Address: _____ Employer: _____ Marital Status:_____

_____ Do you prefer to be contacted by: ☐ Email ☐ Text ☐ Phone/ Voicemail

Spouse Name (or parent): _____ Spouse (or parent) D.O.B: ____ /____ /_____

Has a member of your family had an exam in our office? ☐ Yes ☐ No If yes, please list their name(s): _____

How did you hear about our office? ☐ Family member ☐ Friend ☐ Doctor ☐ Insurance plan ☐ Internet ☐ Other: _____

Last eye exam: ____ /____ /_____ Reason for today's visit: _____

Insurance Information

	Insurance Company	Subscriber		Insurance Company	Subscriber
Primary Vision			**Primary Medical**		
Secondary Vision			**Secondary Medical**		

***Patients with VSP (Vision Service Plan), provide the last four digits of your (subscriber's) Social Security number in the ID Number field.**

***Patients with Medicare, provide your entire Social Security number in the ID Number field.**

Eye Health History

Do you work on a computer? ☐ Yes ☐ No If **yes**, distance from eyes to screen? _____Inches

Hobbies/avocations: _____ If **yes**, distance from eyes to activity?_____ inches feet yards

Are you interested in finding out if you are a candidate for refractive surgery (LASIK, PRK)? ☐ Yes ☐ No

Do you have Diabetes? ☐ Yes ☐ No If **yes**, most recent A1c: _____ Last physical exam: ____ /____ /_____

Have you had major surgery? ☐ Yes ☐ No If **yes**, what for? _____ Date of surgery: ____ / ____ / _____

Please list your primary care physician & specialist(s): _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Medications: Please list any you currently use; including hormones, oral contraceptives, vitamins and antihistamines:_____

_____

Dosage: _____ **Medication used for:** _____

Are you allergic to any medications? ☐ Yes ☐ No If **yes**, please list them: _____

Please check all that apply:

Blur at far		Rubbing eyes		Headaches (not tension)	
Blur at near		Excessive tearing		Dizziness/fainting/vertigo	
Temporary loss of vision		Eyelid crusting/matting		Color deficiency	
Fluctuating vision		Eye infection/disease		Night vision problems	
Double vision		Frequent styes		Vision therapy	
Eye strain/ Eye fatigue		Flashes of light		Eyeturn/lazy eye/head tilt	
Eye pain/Pain on eye movement		Floating Spots		Learning disability	
Eye redness		Light sensitivity		Dyslexia/letter/word reveals	
Eye itching/burning		Halos around lights		Herpes Simplex/Zoster	
Eyelid twitching		Eye surgery		Prosthetic eye	
Eye dryness		Eye or head injury			

PLEASE COMPLETE THE BACK OF THIS FORM

Optomap Retinal Exam (dilation may not be required)

Please review the laminated information sheet about retinal photography. We offer this in our office because, even without dilation, it provides ultra wide angle and layered views of the retina. This allows Dr. Balter to discover potentially sight or life threatening conditions more easily. Dr. Balter recommends an annual scan of your retina to ensure the health of your eyes, even if you are having your eyes dilated. The fee for this service is **$39.00** and generally not covered by insurance.

☐ I have elected to have an Optomap Retinal Exam today.

☐ I have elected **NOT** to have an Optomap Retinal Exam today. **Initials:**_____

Eye dilation enhances the ability to examine your retina. This may cause your eyes to be more sensitive to light and could affect your ability to read or drive for approximately 3 to 5 hours. Please select one of the following options:

☐ **Yes**, okay to dilate eyes today.

☐ **No**, I elect not to have this procedure done. I understand this limits Dr. Balter's ability to thoroughly examine my eyes and rule out potential sight or life-threatening conditions.

Signature:_____

Contact Lens Wearers

Would you like to have a contact lens evaluation/fitting in order to determine your current contact lens prescription? ☐ **Yes** ☐ **No**

In order to determine your contact lens prescription or renew your current contact lens prescription, a new fitting or re-evaluation is REQUIRED. A separate fee will apply and is occasionally covered by insurance since contact lenses are considered cosmetic and unnecessary to correct your vision. We ask that you wear your current contact lenses into your appointment. By doing this you may avoid additional follow-up visits, saving you time and possibly additional costs.

Do you wear contact lenses? ☐ Yes ☐ No If **yes**, what type do you use? ☐ soft contact lenses ☐ rigid gas perm lenses

How often do you change your lenses? ☐ daily ☐ bi-weekly ☐ monthly ☐ other: _____

Do you sleep in your contact lenses? ☐ Yes ☐ No What brand of solution do you currently use: _____

How often do you wear contact lenses? ☐ Full-time ☐ Part-time If **part-time**, how often? _____

Are you happy with your current contact lens brand? ☐ Yes ☐ No If not, why not? _____

***A contact lens is a medical device that rests on the surface of the eye. They must fit well and be worn properly to avoid risk to your eyes and vision.**

Privacy Policy

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

Signature:_____ **Date**:____/____/_____

Payment Information

Due to increased insurance plan changes this year please read the following carefully: Your insurance plan may require a referral from a primary care physician prior to obtaining services for specialty care. This applies to HMO plans especially, but may apply to any insurance plan. As a patient, you are responsible for securing referrals from your primary care physician before making an appointment to see a specialist. If you have not contacted your primary care physician to obtain a referral please take this time to contact them before you see Dr. Balter. Should you choose to see Dr. Balter prior to receiving a referral you will be required to pay the estimated cost of the services you receive prior to leaving your appointment. If a referral is obtained after your appointment and your insurance processes the claim you will be reimbursed once we receive payment from your insurance company.

Signature:_____ **Date:**____ / ____ / _____

By signing here I understand that I am responsible for payment to Dr. Mark Balter if I have not requested a referral from my primary care physician or my insurance claim is denied.

If we are a provider for your plan, we will bill your insurance company for you for any covered services and materials. It is your responsibility to know the terms of your coverage, and it is crucial that you provide correct information in order to ensure prompt and proper processing of your claim. If possible, we will verify your insurance coverage prior to your visit; however, please be aware that any coverage quotes are not a guarantee of payment. Some of the services and materials provided by Northwest Vision Clinic may not be covered by your plan. It will be your responsibility to pay any balance due for these items.

ANY AMOUNT NOT COVERED BY INSURANCE WILL BE DUE AT THE TIME OF SERVICE INCLUDING COPAYS, CO-INSURANCE AND DEDUCTIBLES. A MINIMUM 50% DEPOSIT IS REQUIRED BEFORE MATERIALS ARE ORDERED FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, DEBIT, VISA OR MASTERCARD.

I request that payment of insurance benefits for services and materials furnished to me by this office be made directly to Mark D. Balter, O.D., P.S. I authorize the release of medical information to my insurance company in order to determine the benefits and to process the claims.

I understand that I am responsible for charges not paid by the insurance plan.

The above information is complete to the best of my knowledge. I agree to the above terms and conditions. In the event action should become necessary to collect any unpaid balance, I/we agree to pay all service charges, collection fees, reasonable attorney's fees, filing fees, and any other related costs that the court determines proper.

Signature:_____ **Date:**____ / ____ /_____