Welcome to Hermitage Eye Care

Today's Date: ___/___/_____

Patient Information

Patient Name: _____ Preferred Name: _____ Date of Birth: __/__/____

Preferred Method of Communication: _____ OK to leave vmail when calling? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

I authorize Hermitage Eye Care PLLC to speak to the following about: (HIPAA law makes it illegal for information to be released without patient's written authorization)

1. _____ ☐ Appointments ☐ Orders ☐ Medical ☐ Financial
   Name
2. _____ ☐ Appointments ☐ Orders ☐ Medical ☐ Financial
   Name

I acknowledge that I have received or have been offered a copy of Hermitage Eye Care's Notice of Privacy Practices.

Signature: _____ Date: ___/___/_____

Please sign the following statement which allows Hermitage Eye Care PLLC to file with your insurance company: I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to Hermitage Eye Care PLLC. I understand that I am financially responsible for all charges not paid by insurance. I authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature for all insurance submissions.

Signature: _____ Date: ___/___/_____

I authorize Hermitage Eye Care PLLC to disclose my individual information (i.e. name, address, telephone #, appointment dates and time) for the purpose of recalling lists to remind me of my next appointment time and to provide me with announcements and service/product information from this office.

Signature: _____ Date: ___/___/_____

Medicare Patients: I request that payment of authorized Medicare benefits be made on my behalf to Hermitage Eye Care PLLC for any services furnished to me by the provider. 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 that I will be financially responsible for charges not covered by Medicare, such as a refraction, CPT 92015. Other charges not covered by the Medicare program include additional patient options for glasses including, but not limited to tints, scratch coat, progressive lens, contact lens solutions, cleaners and some digital photos.

I also request payment of authorized Medigap benefits be made on my behalf to Hermitage Eye Care PLLC for any services furnished to me.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: ___/___/_____

For all patients over the age of 18: Hermitage Eye Care's comprehensive eye exam includes both a vision exam and an eye health exam which includes retinal photography. Most vision insurance plans do not cover the retinal photos. Under those plans a discounted retinal photography fee of $39 will be charged. Please initial acknowledgement: _____

Name _____ Date_____

Patient Interview

Have you ever been diagnosed with any of the following?

❑ Cataract ❑ Diabetes ❑ Floaters and/or flashes of light

❑ Macular Degeneration ❑ Dry Eye ❑ Iritis or Uvetis
❑ Glaucoma ❑ Eye Infection, inflammation, allergies ❑ Retinal conditions
❑ Other _____

Are you currently experiencing any of the following?

❑ Redness ❑ Itching ❑ Discharge
❑ Burning ❑ Tearing ❑ Other _____

❑ Blurred Vision ❑ Sensitivity to Light ❑ Night Glare
❑ Eye Strain ❑ Headache ❑ Double Vision
❑ Eye Pain ❑ Poor Night Vision ❑ Total Loss of Vision

Please tell me about your current corrective lenses:

What corrective lenses are you mainly using for **far/distance** vision activities?

No Correction Eyeglasses Contact lenses

Describe the quality of your **distance** vision:

Acceptable May need improvement Blurred

What corrective lenses are you mainly using for **near/reading** vision activities?

No Correction Eyeglasses Contact lenses

Describe the quality of your **near** vision:

Acceptable May need improvement Blurred

If you use a **computer,** what corrective lenses are you mainly using?

No Correction Eyeglasses Contact lenses CL's with glasses

Describe the quality of your **computer** vision:

Acceptable Blurred May need improvement

Do you have any specific computer demands on your vision?

Extended Use Simultaneous view of screen/paperwork Multiple Desktops Other _____

Do you have any special outdoor demands? _____

Do you have any special desires for your eyeglasses?

❑ Broken or lost eyeglasses ❑ Interest in Fashion ❑ Thinner/Lighter Lenses ❑ Reduce glare

Are there any additional concerns with your corrective lenses?

_____