RETINAL SCREENING:

Retinal Wellness Scans are included in all Adult Vision Exams at an additional $20.00 plus all other co-pays.

OASIS EYECARE

Intake Form

New Patient	Yes
Existing Patient	Yes

Office use: Plan covers photos: Yes / No

Date ____ / _____ / 20___ **Exam desired: ☐ Eyeglasses Exam ☐ Contact Lens & Eyeglasses Exam ☐ Medical Office visit**

Name _____ DOB ___ / ____ / _____ Social Security last 4# _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____ Gender: Male / Female Married: Yes / No Spouse: _____

Occupation _____ Employer _____

How would you like for us to communicate with you? ☐ Home phone ☐ Cell phone ☐ Email ☐ All

Insurance: Vision: _____ Medical: _____

Primary Account Holder _____ Policy # _____

Medication & Allergy Information

Penicillin Allergy? Yes or No	Sulfur Allergy? Yes or No	Seasonal Allergies? Yes or No	Other Allergies:	Do you take Plaquenil or Amiodarone? Yes or No

List **all** medications you are currently taking or provide a list (including eye drops):

_____

Review of System Health

Please list all medical conditions: _____

What was the **date of and location of your Last Eye Exam**? Are you currently experiencing any **eye related problems**? Please Explain.

_____

Health History: Please identify if **You** or an **Immediate family member** has any of the following:

You ONLY (Yes/No)

Sinus Problems	Y/N
Asthma/Breathing	Y/N
Kidney disease	Y/N
Arthritis	Y/N
Intestinal	Y/N
Skin Problems	Y/N
Migraines	Y/N
Psychiatric	Y/N
Anemia	Y/N
Sleep Apnea	Y/N
AIDS/HIV	Y/N
Pregnant/Nursing	Y/N

You & Your Family History: list members as - *Mother (M), Father (F), Sibling (S), or Grandparent (GP)*
(Circle the conditions you have)

High Blood Pressure	_____	Glaucoma	_____	Retinal Detachment	_____
High Cholesterol	_____	Cataracts	_____	Macular Degeneration	_____
Thyroid	_____	Lazy Eye	_____	Blindness	_____
Heart Disease	_____				
Cancer & Type	_____				
Diabetes	_____				
Stroke	_____				

If **you are a diabetic, list your last blood sugar & A1c:_____*
list the year you were diagnosed with diabetes _____

Have **you** had any eye injuries/eye infections? Explain & year _____

Family Physician_____ Last exam _____

Hobbies? _____ Sports? _____

Do you use Alcohol? ☐ Socially ☐ Frequent ☐ Never Type: ☐ Beer ☐ Wine ☐ Hard Liquor
Do you use any of the following recreational items? ☐ Marijuana ☐ Tobacco ____ packs/day # years _____ ☐ Stopped

Please list any **previous surgeries** below. (***Please include eye and non- eye related surgeries with surgery year)*** _____

Financial Policy

INSURANCE COVERAGE: **INITIAL** _____

It is important for you to provide our office with accurate information for billing your insurance plan properly at the time of service. You must present your card at each visit if your insurance company has provided you with one.

I hereby **authorize payment** of medical and vision benefits **billed to my insurance** to Oasis Eyecare. I have listed **all health insurance plans** from which I may receive benefits. **I hereby accept responsibility for payment for any service(s) provided to me that is not covered** by my insurance. I agree to pay all co-payments, coinsurance, deductibles, and non-covered services/items at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurances, if **Oasis Eyecare does not participate with my insurance. I hereby authorize Oasis Eyecare to use and/or disclose my health information** which specifically identifies me, or which can reasonable be used to identify me to carry out my treatment, **payment,** and healthcare operations.

AMOUNTS DUE FROM THE PATIENTS: **INITIAL** _____

Insurance co-payments are due at the time of services. If we do not participate with your insurance plan, payment must be paid in full. We will provide an itemized statement of services and amounts paid which you can submit to your insurance carrier. Your carrier will be responsible for reimbursing you. Note, some insurances might pay less for out of network charges.

Consent to Release Information: **INITIAL** _____

On occasion, it might be necessary to release your information to a family member or other health professional. Please indicate whom you **authorize to obtain your information. Please indicate Relationship: Doctor or Family (Parent, sibling, spouse, etc.)**

Name _____
Relationship: Address , City, State, Zip Phone:

Name _____
Relationship: Address , City, State, Zip Phone:

NOTICE OF PRIVACY PRACTICES

We are required by law to keep health information that identifies you private and to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

ACKNOWLEDGEMENT OF RECEIPT (Sign below)

I acknowledge that I received a copy of Oasis Eyecare's Notice of Privacy Practices.

Date _____ **Patient name**_____ **Signature** _____
(Print)

CONSENT TO DILATE (Check below)

( ) I consent to have my eyes dilated today **( ) I decline to have my eyes dilated today.**

OFFICE USE ONLY

Manifest Rx: OD: _____ 20/ **CTL Rx:** OD: _____ 20/

OS: _____ 20/ OS: _____ 20/

ADD _+_____ Brand: _____/BC_____/ Diam____

ICD-10: 92004 New- Comp 92002 NP-limited 92310 Contact Lens Exam 99203 Medical New 3 Medicaid: SO620 NP
92014 EP-Comp 92012 EP- limited 99201 Medical New 1 Tech 99204 Medical New 4 SO621 EP
92015 Refraction 99202 Medical New 2

Photos: Yes/No
92250-52 (Wellness)

OCT: Yes/No
9213x-52 (Wellness)
2-AS, 3-ONH, 4-Retina

Visual field: Yes/No
92082 Interm/ 92083 Extd

Pachy: Yes/No
76514

Gonio: Yes/No
92020