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

Name _____ Gender: Male / Female DOB ___ / ____ / _____ Social Security last 4# _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____ Married: Yes / No Spouse Name: _____

Occupation _____ Employer _____

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

Insurance: Vision/Policy #: _____ Medical/Policy #: _____

Primary Account Holder's Name _____ DOB ___ / ____ / _____ Social Security last 4# _____

Medication & Allergy Information

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

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

_____

Review of System Health

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** have any of the following conditions:

You ONLY (Yes/No)

Glaucoma	Y/N	High Blood Pressure	Y/N	Sinus Problems	Y/N
Cataracts	Y/N	High Cholesterol	Y/N	Asthma/Breathing	Y/N
Macular Degeneration	Y/N	Thyroid Disorder	Y/N	Kidney disease	Y/N
Retinal Detachment	Y/N	Heart Disease	Y/N	Arthritis	Y/N
Crossed/Lazy Eye	Y/N	Cancer & Type	Y/N	Intestinal	Y/N
Blindness	Y/N	_____		Migraines	Y/N
Eye Injury/Infection	Y/N	_____		Skin Problems	Y/N
which eye & when?		Stroke	Y/N	_____	
_____		Other _____		Psychiatric	Y/N
_____		_____		_____	
_____				Anemia	Y/N
Diabetes	Y/N			Sleep Apnea	Y/N
Year diagnosed_____				AIDS/HIV	Y/N
Last A1c & date_____				Pregnant/Nursing	Y/N
Last blood sugar reading & taken_____					

Family ONLY- List member with the condition as - Mother (M), Father (F), Grandparent (GM, GF), Sister (S), or Brother (B)

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

Family Physician/ Hospital _____ Last PCP 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**. (***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, St, Zip Phone #

Name _____
Relationship Address , City, St, 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. If so, scans must be done to assess the eyes.**

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	**OCT: Yes/No**	**Visual field: Yes/No**	**Pachy: Yes/No**	**Gonio: Yes/No**
92250-52 (Wellness)	9213x-52 (Wellness) 2-AS, 3-ONH, 4-Retina	92082 Interm/ 92083 Extd	76514	92020