Kirsten Wilgers, OD
Brian Peterson. OD

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this in order to give you the best care possible.

- **Completed Welcome to the Office Form**: This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff and remind us to address any significant issues during your visit.

- **Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a "whole person" rather than just a pair of eyes.

- **Insurance cards / Photo ID:** For any optical and/or medical insurance under which you may be covered. (Even for "routine" visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination).

- **Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

- **Contact Lenses:** It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your boxes or lens packets that indicate the lens series, power, manufacturer, etc.

- **Medications:** Please bring a complete list of prescription and non-prescription medications and eye drops.

- **Children:** *Parents or legal guardians must accompany anyone **not** of legal age.* Also, ask your parent to bring along any referral forms if a problem was found at school or Head Start screening, etc. This will help us to confirm or rule out the suspected problem most efficiently.

- **Dilation Explained**: The doctor may need to use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at a near (reading) distance. Therefore, if you want new eye-wear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection.

- **Retinal Imaging Recommended:** The doctor strongly recommends that each patient receives the retinal imaging package. This includes a high definition picture of the back of the eyes as well as an ocular scan of the underlying layers of the back of the eyes. This will allow the doctor to see more than what they could see with just the dilated eye exam. This is not meant to replace the dilation, but it's strongly advised if the patient defers dilation at the exam. The retinal I-wellness package is $75.00 and will not be covered by your insurance.

Completing the task list for the items that apply to you will assure that you receive the most thorough and professional care possible and in a very efficient manner. We look forward to your visit!

TOTAL VISION
Eye Health Associates
The First Choice in Eye Care

Date: ___ DoB: _____ Age: _____Sex: _____
Name: _____ _____ Employer (or school): _____
Address: _____ Occupation (or grade): _____
City: _____ State: ____ Zip: _____ Spouse
Cell Phone: (_____)_____ Children: _____
Secondary Phone: _____ Email: _____
Race/Ethnicity: _____ Marital Status: _____

Patient Eye History
(check all that apply)

- ○ Eye Injury
- ○ Eye Surgery
- ○ Lazy Eye
- ○ Cataracts
- ○ Glaucoma
- ○ Macular Degeneration
- ○ Other: _____

Patient Medical History
(check all that apply)

- ○ Asthma
- ○ Arthritis
- ○ Blood Pressure (hi/low)
- ○ Cancer
- ○ Diabetes: T1 T2
- ○ Thyroid (hyper/hypo)
- ○ Other: _____

Medications:

Family Medical/Eye History
(check all that apply)

Relationship

- ○ Blindness _____
- ○ Cataracts _____
- ○ Glaucoma _____
- ○ Macular Degeneration _____
- ○ Diabetes _____
- ○ Other_____

Drug Allergies:

Primary Care Physician:
_____

Reason for today's visit

What is the **primary** purpose of this visit?

_____

When did you first notice this problem?

_____

Do you experience any of the following?

- ○ Blurred vision
- ○ Headaches
- ○ Flashing Lights
- ○ Computer Problem
- ○ Sports Vision Problem
- ○ Infection/Red or Painful Eye
- ○ Other Eye Problem _____

Do you... (check all that apply)

- ○ Work at a computer? _____ Hours/day
- ○ Have prescription sun glasses?
- ○ Want info on laser vision correction?

How did you hear about Total Vision?

- ○ Referred by a friend/relative
  If so, whom? _____
- ○ Referred by health care practitioner
  If so, whom? _____

If you wear glasses:

Are there times you would rather not have to wear them?	Yes	No
Would you like them thinner and lighter?	Yes	No
Are you bothered by bifocal lines and head tilting?	Yes	No
Are they 100% UV protective?	Yes	No
Do you tend to scratch your lenses?	Yes	No
Are you bothered by glare?	Yes	No

Contact lenses:

- ○ Participate in recreation/sports?
- ○ Need new glasses?
- ○ Need new contact lenses?

What are your hobbies?

_____

_____

_____

Have you ever worn contact lenses? Yes No

How often do you replace your contact lenses? _____

Do you sleep in your contacts? Yes No

How many hours per day do you wear your contacts?_____

What brand do you currently wear? _____

Right Lens Rx: _____

Left Lens Rx: _____

Are you interested in contacts? Yes No

Insurance Information

Vision Insurance

- ○ VSP
- ○ EyeMed
- ○ Other: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Subscriber ID or SS#: _____

Primary Medical Insurance

- ○ Medicare
- ○ Florida Health Care
- ○ HFHP Sunsaver
- ○ Humana Gold + HMO/PPO
- ○ GEHA
- ○ UHC
- ○ Other: _____

Subscriber Name: _____

Subscriber Birthdate: _____

How will you be settling your account today?

○ Cash ○ Check ○ Credit Card

(It is customary to pay professional fees, including co-payments, when services are rendered. Verification of covered deductible is required.)

I, the undersigned, hereby acknowledge that I have read and understand the payment policies of this office as outlined above. I also agree that all payments for services be made at each visit. Also, I am responsible for payment of all services rendered by the doctors of Total Vision which are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services.

Signature _____ Date _____

(Please ask our receptionist if you have any questions. Thank you)

Lifetime Insurance Authorization

Medicare And Accepted Major Medical Insurance

I request that payment of authorized Primary and Supplement Insurance benefits be made

either to me or on my behalf for any service furnished by my doctor at T

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature _____ Date _____

HIPPA Compliance Notice

Please review this carefully

This notice describes how medical information about you may be used and disclosed, and how you are able to obtain this information.

We understand that your medical information is personal to you, and we are committed to protecting your medical information. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide for you. By law, we are required to make sure your health information is kept private.

Here are a few examples how we will use or disclose your information:

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our office more efficiently and provide quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers compensation programs
- In response to certain requests arising out of lawsuits/disputes

If you feel that your privacy rights have been violated, you are able to file a complaint with the office manager or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

The rights you have regarding your information include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to an accounting of disclosures
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices.

Signed by:_____ Date:_____

Print name:_____

I give permission to Total Vision to release my medical information and/or records to the following:
(friends/family members/other doctors you may be seeing)

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____