CITRUS VISION
Trusted Eye Care Since 1965

Brad Cook, OD
2332 Hwy 44 W
Inverness, FL 34453
Phone : (352) 726-2085
Fax : (352) 726-2738
www.citrusvisionclinic.com

QUESTIONNAIRE

DEMOGRAPHIC

Today's Date_____

Last _____

First _____ **MI** _____

DOB_____ **Gender** □ Male □ Female

SSN: _____ - _____ - _____

Street _____

City _____ **State** _____

Zip Code_____

Home Phone_____

Work/Daytime Phone _____

Cell Phone _____

Ok to text? □ yes □ no

Email _____

Marital Status □ Minor □ Single □ Married
□ Domestic Partner □ Seperated □ Divorced □ Widowed

Spouse/Parent's Name _____

Employer/School _____

Occupation/Grade _____

Race _____
□ Declined to Specifiy

Ethnicity □ Hispanic or Latin □ Not Hispanic or Latino
□ Filipino □ Declined to specify

Preferred Language _____

INSURANCE

Please note <u>most</u> insurance plans do NOT cover the entire cost of glasses, Contact Lens Evaluations or Follow- Ups.
In many cases the refraction may also not be covered.

Vision : _____

Primary's Name: _____

Primary's ID: _____

Primary's DOB: _____
Patient's Relationship to Primary (circle one)
self child spouse domestic partner

Medical :_____

Primary's Name :_____

Primary's ID : _____

Primary's DOB: _____
Patient's Relationship to Primary (circle one)
self child spouse domestic partner

Secondary :_____
This includes supplements and other vision plans

Primary's Name :_____

Primary's ID : _____

Primary's DOB: _____
Patient's Relationship to Primary (circle one)
self child spouse domestic partner

Primary Care Physician: _____
□ None City : _____
Phone : _____

Who may we thank for referring you to our office?

□ Another Dr. □ Insurance List □ Saw sign/building □ Yellow Pages □ Previous Patient □ Our Website
□ Chamber of Commerce □ Friend/Family Member □ City of Inverness Website □ Postcard/Mailer
□ Charity Auction/Raffle □ One of our Employees □ Newspaper/Radio/TV Ad □ Other _____

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QUESTIONNAIRE

VISION

Today's Date_____

Last _____

First_____ MI _____

DOB _____ Gender □ Male □ Female

What is the purpose of this visit?

_____

_____

_____

Are you currently experiencing any of the following EYE related symptoms? (circle all that apply)

Double Vision Pain Flashes/Floaters
Loss of Vision

Other : _____

Date of last eye exam _____

Location of last eye exam? _____

Do you…….. (check box if your answer is yes)

□….work at a computer or use other tech devices?

□…currently wear glasses or contact lenses?

□…have prescription sunwear?

□…have more than one pair of your current prescription?

□…require safety glasses for your job or hobbies?

What do you like/dislike about your glasses?

Like:_____

Dislike:_____

Have you ever tried contact lenses? □ yes □ no

Do you currently wear contact lenses? □ yes □ no

If so, what kind/brand? _____

Do you sleep in your contacts? □ yes □ no

Are you satisfied with your contact lenses?

Vision □ yes □ no Comfort □ yes □ no

Why? _____

MEDICAL

There are many different levels of eye care. We are your primary eye care provider. If your needs exceed routine care, you may be referred to a specialist for your eye exam. This would not prohibit you from filling your eyeglass prescription here.

_

Current RX Medications (include dosage)

_____

_____

_____

_____

SOCIAL HISTORY Do (Did) You

Smoke □ No □ Yes □ Former How many per day?

Drink □ No □ Yes □ Former How many per day?

MEDICAL EYE HISTORY

Is there a family history of any of the following?
M = Mother F = Father S = Sister B = Brother

Blindness/Eye Injury/ Surgery	Self	M	F	B	S
Cataracts at an early age	Self	M	F	B	S
Corneal Problems	Self	M	F	B	S
Diabetes	Self	M	F	B	S
Glaucoma	Self	M	F	B	S
Lazy Eye	Self	M	F	B	S
Macular Degeneration	Self	M	F	B	S

Any other eye issues? _____

Self M F B S

Allergic to medications? : _____

Please circle any hobbies you participate in:

Reading Boating Fishing Crafting/Sewing Golf Woodworking Painting Computers

Musical Instrument Running Bicyling Swimming/Diving Cooking Motorcycles

Other _____ _____ _____

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OFFICE PAYMENT POLICY

Please read the following information regarding our financial policies.

Patients With Insurance

- **Please note you will be required to pay your co-payment and/or deductible at the time of your visit.** If we are filing an insurance claim for your services please note that once your claim has processed you will be billed for any balance that has not been paid by your insurance company as per the explanation of payment.
- If you are covered by an insurance plan that that the doctor ***does not participate with***, you will be required to pay for your office visits and/or any procedures at the time of service. We will then provide you with proof of payment for you to submit to your insurance company for reimbursement. This is referred to as "self filing".

Patients Without Insurance

- **Patients not covered by insurance are expected to pay for services at the time that they are rendered. Any other arrangements must be made *in advance* and approved by calling our billing department. We do accept cash, checks, money orders, Visa, MasterCard, Discover, and Care Credit.**

I HEREBY AUTHORIZE CITRUS VISION CLINIC, IE, VICTOR T NOTHANGEL OD, PA, TO FILE FOR ANY SERVICES FURNISHED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE INSURANCE COMPANIES OR AGENTS AS NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY VICTOR T NOTHNAGEL, OD, PA. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MEDICARE AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.
I PERMIT A COPY OF THIS TO BE USED IN PLACE OF AN ORIGINAL.
I REQUEST THAT PAYMENT FOR AUTHORIZED SUPPLEMENTARY BENEFITS BE MADE ON MY BEHALF TO VICTOR T NOTHNAGEL, OD, PA, FOR ANY RELATED SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO MY SUPPLEMENTAL INSURER, ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

Eyeglass Orders: We will allow up to 12 hours to cancel an eyewear order. Acceptable methods of cancellations include: Speaking directly with the sales associate or office manager or by leaving a voicemail within 12 hours of placing the order.

No refunds will be issued on clinical procedures, services or prescription lenses.

Your insurance is a contract between you and your insurance company.

I understand that all charges are my responsibility from the date services are rendered.
I have read and understand the above payment policy and Refund/Return policies.

Signature:_____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

At Citrus Vision Clinic we have always kept your health information secure and confidential. Law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your chart by a specialist doctor whom we may involve in your care.
- We may use and disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use or disclose your health information when calling in prescriptions to a pharmacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave information on your answering machine/voicemail or with the person answering the telephone.
- In an emergency, we may disclose information to a family member or another person responsible for your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company or even give your insurance company information in order to acquire an authorization for services.
- We may release some or all of your health information when required by law.
- If the practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
You have the right to know if any users or disclosers we make with your health information beyond the normal uses.
As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
You have the right to see or even transfer copies of your health information to another practice by providing a written request regarding the information you want to see or have sent and we will mail or fax it for you.
You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If you have a question or complaint in regards to our privacy practices, please contact Citrus Vision Clinic at (352) 726-2085.

ACKNOWLEDGEMENT:
I have reviewed the Privacy Policy of Citrus Vision Clinic.

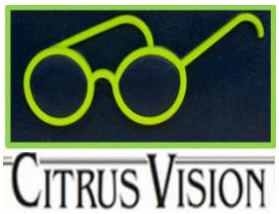
Signed : _____ Printed Name:_____

Date:_____

I give the following people permission to access my records or to have disclosure regarding my care.

_____ _____

_____ _____



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Release of Previous Eye Care Records

If you are new to our office or have been seen elsewhere since your last eye exam with us, please fill out the following release form.

Please release the records of : _____

Date of Birth : _____

Last 4 of SSN : _____

Release From : _____

_____

_____

☐ Most recent eye exam

☐ Any medical eye testing

☐ My prescription for glasses and contacts lenses

Please mail or fax records to the above address.

Thank you,

_____ _____

Signature Date

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Are Contact Lenses Right For You?

Questions to ask yourself if you are considering contact lenses for the ***first time.***

Please review the following questionnaire and choose "YES" or "NO"

YES	NO	
		Do you wear progressive, bifocal, or lenses to correct astigmatism currently in your glasses?
		Do you have dry eyes?
		Do you have allergies?
		Do you work in dusty conditions or outdoors?
		Do you expect superb vision in contact lenses for both near and distance vision?
		Have you had corrective eye surgery, such as Lasik, PRK, or cataract?
		Do you have a history of cornea issues? (deterioration, irregularity, scarring, injury)

If you answered "YES" to two or more of these questions, contact lenses may not be right for you.

There are certain diagnosis or eye health history that determine your candidacy for contact lenses. Beyond that, the biggest factors in contact lens success are your ability to have realistic expectations and your willingness to compromise.

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Soft Contact Lens Evaluation History

Current Soft Contact Lens Wearer Information

How is your vision with your contact lenses?

	Poor	Good
Distance	□	□
Near	□	□
Computer	□	□

How often do you replace your contact lenses?

□ Daily □ Weekly
□ Bi-weekly □ Monthly
□ Other _____

What brand and powers of lenses are you currently wearing?

Right Eye _____

Left Eye _____

How many years have you worn contact lenses? _____

How many hours per day do you wear your contact lenses? ____

After how many hours do the lenses feel dry?
□ 1-5 □ 6-10 □ 11-15 □ Never

Which contact lens solutions do you prefer and which solutions have you had a reaction to, if any?

Prefer		Reaction	
□ Renu	□ Complete	□ Renu	□ Complete
□ Opti-Free	□ Clear Care	□ Opti-Free	□ Clear Care
□ Generic	□ Other_____	□ Equate	□ Other _____

How many nights in a row do you sleep in your contact lenses?
□ 1-7 nights □ 2-3 weeks □ None
□ Occasional □ 1 month
□ Other _____

	Yes	No
Do you have difficulty inserting or removing your contact lenses?	□	□
Do you wear distance only contacts with over-the-counter reading glasses?	□	□
Do you wear monovision contact lenses where one eye is distance and one is near?	□	□
If yes, which eye is for distance? □ Right □ Left		
Have you tried bifocal contact lenses?	□	□
Have you tried other brands of contacts that you like better than your current brand?	□	□
Have you ever been told you have neovascularization, a condition in which blood vessels grow into the cornea due to a lack of oxygen reaching the eye?	□	□

Current and New Contact Lens Wearers

	Yes	No
If you have not worn contacts, does anyone in your home wear them? Whom?_____	□	□
Do you work in an environment that might make wearing contacts challenging, such as a dusty or extremely dry environment? Please explain _____	□	□
Do you want ot wear your contact lenses full time?	□	□
Do you want to wear your contact lenses part time?	□	□

Are you interested in trying any of the following:	Yes	No
Distance only contacts with over-the-counter reading glasses?	□	□
Monovision contacts where one eye is for distance and one eye is for near?	□	□
Bifocal contact lenses?	□	□
New/Different brands of contacts lenses?	□	□
Sleeping in your contacts?	□	□
Enhancing/Changing your eye color?	□	□

**** If you have a history of chronic or contact lens related eye infections or problems (ie, ulcers or scarring) or you have had eye surgeries including Lasik, PRK, or Cataract, you may not be a candidate for contact lenses.***

Contact Lens Pricing

Fitting/Evaluation $65.00 - $100.00 Insertion/Removal Training $35.00 Follow up Visit $30.00/ each
Annual Supply Contact Lens Pricing $240 - $850 before insurance benefit or mail in rebate is applied