Patient's Name: _____ Patient SSN: _____ DOB: _____ Age: _____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone: _____ Text Messaging? Y / N Secondary Phone:_____ Home/Work/Other

Email: _____ Sex: M / F Marital Status: Single / Married / Divorced /Widowed

Employer:_____ Occupation:_____

Emergency Contact/Parent if Minor:_____ Relationship: _____ Phone:_____

Primary Care Physician:_____ Phone #_____

Pharmacy:_____ Phone #_____

Preferred Language:
- English
- Spanish

Select Ethnicity:
- Hispanic or Latino
- Native Hawaiian/Other Pacific Islander
- Not Hispanic or Latino

Select one or more of the following races:
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

INSURANCE COVERAGE

MEDICAL INSURANCE:

Name of Company:_____ ID#:_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's DOB:_____ Policy Holder's SSN:_____

Policy Holder's Address if Different From Patient:_____

VISION INSURANCE:

Name of Company:_____ ID#:_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's DOB:_____ Policy Holder's SSN:_____

Policy Holder's Address if Different From Patient:_____

Statement of Financial Responsibility

You as the Patient are financially responsible for all charges for any and all services rendered. This includes any medical services, routine examinations, refractions, testing, contact lens fitting fees and any other screening ordered by the Doctor.

You are responsible for informing the office of any changes to your medical or vision insurance coverages. If your Insurance coverage is terminated at the time of service, or retroactively terminated by your employer, you are financially responsible for the balance in full.

It is your responsibility to know if your insurance has any deductibles, co-payments, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitations for the services you receive and to make the payment in full at the time of service. While your insurance company may confirm benefits, a confirmation of benefits is not a guarantee of payment, and you are responsible for any and all balances.

If you are a Medicare patient, you must provide our office with both your Medicare ID card and your secondary Insurance ID card. Your secondary insurance cannot be billed if we do not have the correct insurance information on file. You will then be responsible for paying the balance due.

I understand that I am assigning my insurance benefits directly to Rogers Regional Eye Center/Dr. Kevin Rogers.

By signing below, you acknowledge that the information you have provided to our office is correct and that you have read, understand and agree to the terms and conditions of the statement of financial responsibility.

Printed Name:_____ If Minor, Guardian's Name:_____

Signature:_____ Date:_____

Medical History Questionnaire

Medications:_____

_____

_____

_____

Medication Allergies (specify reaction):_____

_____

Surgeries or Serious Illnesses:_____

_____

Family History

Please note any family member with any of the following:
(M=Mother, F=Father, S=Sibling, GP=Grandparent)

- ☐ Arthritis ____
- ☐ Blindness ____
- ☐ Cancer ____
- ☐ Cataracts ____
- ☐ Crossed Eyes ____
- ☐ Macular Degeneration ____
- ☐ Lupus ____
- ☐ Diabetes ____
- ☐ Glaucoma ____
- ☐ Heart Disease ____
- ☐ High Blood Pressure ____
- ☐ Retinal Disease ____
- ☐ Thyroid Disease ____
- ☐ Sjogren's Syndrome ____

Social History

- ☐ Never Smoked
- ☐ Former Smoker Years Quit_____
- ☐ Current Smoker Packs/Day_____
- ☐ Current Smokeless Tobacco User
- ☐ Alcohol Use Never
- ☐ Alcohol Use Social
- ☐ Alcohol Use Daily

PERSONAL HEALTH HISTORY Please indicate if you have a history of any of the following:

EYES

- ☐ Blurred Vision
- ☐ Burning
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Distorted Vision (Halos)
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/ Watering
- ☐ Eye pain/ soreness
- ☐ Flashes of light in vision
- ☐ Floaters in vision
- ☐ Glare/ Light Sensitivity
- ☐ Glaucoma
- ☐ Infection of Eye or Lid
- ☐ Itching
- ☐ Lazy Eye
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Retinal Disease
- ☐ Sandy/ Gritty Feeling
- ☐ Styes or Chalazion

EAR, NOSE, MOUTH & THROAT

- ☐ Chronic Cough
- ☐ Dry Mouth
- ☐ Sinusitis

CARDIOVASCULAR

- ☐ Hypertension/High Blood Pressure
- ☐ Stroke

CONSTITUTIONAL

- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

ENDOCRINE

- ☐ Cholesterol Elevated
- ☐ Diabetes Mellitus
- ☐ Diabetic Suspect/ Pre-Diabetic
- ☐ Insulin Resistant
- ☐ Thyroid Disorder

GASTROINTESTINAL (Stomach)

- ☐ Diarrhea
- ☐ Ulcers
- ☐ Constipation

GENITOURINARY

- ☐ Sexually Transmitted Disease
- ☐ Syphilis
- ☐ Kidney Disease

HEMATOLOGIC/LYMPHATIC (Blood)

- ☐ Anemia
- ☐ Leukemia
- ☐ Sickle Sell
- ☐ Hepatitis

IMMUNOLIGIC

- ☐ AIDS
- ☐ Herpes Zoster
- ☐ Lupus
- ☐ Sarcoidosis
- ☐ Sjogren's Syndrome

INTEGUMENTARY (Skin)

- ☐ Psoriasis
- ☐ Eczema

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Arthritis Rheumatoid
- ☐ Joint Pain
- ☐ Muscle Pain

NEUROLOGIC

- ☐ Epilepsy
- ☐ Headache
- ☐ Headache (Migraine)
- ☐ Multiple Sclerosis
- ☐ Seizures

PHYSCIATRIC

- ☐ Anxiety Disorder
- ☐ Depression

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Patient's Name _____

Patient Consent For Treatment and Authorization to Release Medical Information for Assignment of Health Insurance Benefits

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor our statement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this Consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Policies, and the patient does have the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

By signing below, I understand and acknowledge the Practices Privacy and HIPAA Policies. I also acknowledge I am responsible for the payment of all charges for professional services and or goods received regardless of whether or not I have Insurance coverage.

Patient's Signature:_____ Date:_____

Services and Eyewear Purchases Policy

- No refunds will be given on any clinical procedures, exams or services provided by the Doctor.
- Contact lenses are classified as an FDA controlled medical device that must be evaluated and fit to my unique eye each year, even if you are already a contact lens wearer. Contact lens prescriptions are only valid for 12 months. Contact Lens fittings are considered a separate medical procedure, therefore, any and all fees for a contact lens fitting and evaluation are not included in your routine eye exam. Contact lens trial lenses will be given at the time of the exam for you to evaluate the comfort and vision of the lenses. Once you have evaluated the lenses and decide to purchase your supply, no refunds or exchanges will be made.
- Due to the time involved and custom nature of eyeglass fabrication, all purchases are FINAL and no refunds will be given for any reason. Any glasses ordered and not picked up within 6 months from the purchase date, the payment or deposit made will be forfeited by the patient, and the glasses will be disposed of.
- Eyeglass orders are highly customized and cannot be canceled or changed once the order has been placed. Once the insurance benefits are used for the frame and/or lenses those benefits will Not be reinstated.
- We do honor all Manufacturers' Warranties on new frame purchases. Manufacturers will provide a 1year warranty against manufacturer's defects. Frames are not warranted against damage, abuse or accidents. The manufacturer will use their discretion in determining whether the damage was due to a defect or not. We will honor the Manufacturers decision. Some Manufacturers require that the original frame be sent back to them in order for a determination to be made, and this process can take several weeks.
- Lens Manufacturer Warranties are covered against scratches ***only*** if you purchased a Premium Anti-Reflective Glare Coating. The lenses may be replaced once within one year starting from the purchase date of the eyeglasses. Lost lenses or damaged lenses beyond minor scratches are not covered.
- If patients choose to place new lenses into an old frame, we cannot be held liable or responsible for any breaks or damages that might occur to that frame during the process of making new lenses. As frames age, they may become brittle in ways invisible to the human eye. Patients assume the risk when using old frames. Patients also assume the risk when we are making adjustments to older frames.
- Lens remakes and prescription changes on eyewear purchases made from us will be granted within 60 days of the original purchase date. If a patient seeks a redo or remake after the 60 days, they must pay for the new lenses to be made again.

By signing below I acknowledge I have read all of the policies and agree to all of the terms and conditions.

Patient's Signature:_____ Date:_____