IVES EYECARE CENTER

4465 Old William Penn Hwy
Murrysville PA 15668
724/733-1918

Dear New Patient,

Thank you for making an appointment at our office. Please complete the enclosed forms both front and back, and bring them with you to your appointment on _____ at _____am/pm. If you cannot make this appointment please contact the office as soon as possible. We will be happy to reschedule your appointment.

Please bring the following with you:

- All enclosed forms
- Medical Insurance card(s)
- Vision Insurance card(s)

  IF YOUR INSURANCE COMPANY DOES
  NOT SUPPLY YOU WITH AN INSURANCE CARD
  WE WILL NEED THE NAME, SOCIAL SECURITY NUMBER,
  DATE OF BIRTH AND ZIP CODE OF THE
  PRIMARY HOLDER OF THE INSURANCE
- Glasses and/or contacts you are currently wearing

We are looking forward to your visit,

Ives Eyecare Center Staff

Patient Name: _____ Date of Birth: _____

HIPAA Release Form

_____ I have received or declined a copy of the Notice of Privacy Practices in this office.

_____ I authorize the following individuals to speak with IVES EYECARE CENTER staff members regarding my medical records.

- ☐ Family _____
- ☐ Medical Doctors _____
- ☐ Other _____

Communication Preferences

Please fill in all of the methods you allow us to reach you. Please note, our system can only text a cell phone, it cannot call a cell phone.

- ☐ Email: _____
- ☐ Home phone: _____
- ☐ Work phone: _____
- ☐ Cell phone: _____ Texting OK? Yes / No

If you are unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Leave a brief message asking me to return your call.

Patient or Legal Guardian Signature: _____

Date: _____

Ives Eyecare Center
Notice of Billing Practices

I understand that if I am diagnosed with a medical condition such as Cataracts, Glaucoma, Macular Degeneration, Dry Eye, etc. Doctor Ives will perform a medical examination on my eyes and my examination will be billed to my medical insurance.

I understand that should my exam be billed to my medical insurance, I will be responsible for the specialist co-pay listed on my medical insurance card as well as any deductible, co-insurance or any additional co-pays as determined by the Explanation of Payment provided by my insurance company after my claim is filed.

I am aware that if I do not want my medical insurance to be billed, Dr. Ives will perform a vision examination only and will not be monitoring or providing services related to any medical condition such as Cataracts, Glaucoma, Macular Degeneration, Dry Eye, etc.

☐ YES, I want Dr. Ives to perform a medical examination on my eyes if he determines it to be necessary. I understand that if Dr. Ives diagnoses and monitors any medical condition, my medical insurance will be billed.

☐ NO I do not want my medical insurance to be billed. I understand that Dr. Ives will not be monitoring or providing services related to any condition or diagnosis.

SIGNATURE:_____ DATE:_____

Ives Eyecare and Laser Vision Center
Dr. Paul F. Ives
Optometrist

PATIENT'S NAME _____ DATE _____

AGE _____ DATE OF BIRTH_____ SOCIAL SECURITY NO. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

RES. PHONE ( ) _____ CELL PHONE ( )_____ BUS. PHONE ( ) _____

E MAIL ADDRESS _____ is it ok to notify you via e mail ( ) Y ( ) N

FIRM EMPLOYED BY _____ if married name of spouse _____

Spouse's occupation_____ Employed by _____

Eyecare Insurance_____ Medical Insurance _____

Has any member of your immediate family been a patient of Ives Eyecare Center? If yes, please name:

_____

To help our office keep more accurate records, please list any other immediate family members living at home and their ages:

_____

How were you referred to our office? Friend/relative (please name) _____ Yellow Pages_____

Newspaper____ Sign____ Direct Mail____ Company (please specify) _____ Insurance _____ Dr._____

Name, Address, Phone of Primary Care
Physician: _____

Please list all current medications:_____

_____

_____

Have you ever had an allergic reaction to a drug? ( ) Y ( ) N penicillin ( ) Y ( ) N anesthetic ( ) Y ( ) N

Hobbies: _____Sports Activities_____

All co pays are due at the time services are provided. A 50% deposit is required on all materials ordered. Balances are due at dispensing.

Please check your preferred method of payment: Cash _____ Check _____(There will be a $20 fee on all returned checks)

Visa_____ Master Card _____ Discover_____

Thank you for allowing us to assist in your eye health care and visual needs.

Signed _____Date _____

Ives Eyecare and Laser Vision Center
Dr. Paul F. Ives
Optometrist

145 N. Water St.
West Newton PA 15089
(724) 872-5621

4465 Old William Penn Highway
Murrysville PA 15668
(724) 733-1918

Medical History **Name** **Date**

Chief Complaint

How can we help you today? In this space please briefly tell us any signs and symptoms you are experiencing. (Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye pain, itching or burning, glaucoma, cataracts, floaters, dry eyes.)

[ ] Y [ ] N are you thinking of new glasses today?
[ ] Y [ ] N are you thinking of new contact lenses today?
[ ] Y [ ] N are you thinking of new sunglasses today?
[ ] Y [ ] N are you thinking of laser surgery today?

History of present illness **(1, 4)**

Location	Which eye has the problem?	Right eye - Left eye - Both eyes
Quality	Does the problem cause vision loss or blur?	Loss - Blur
Context	Did the problem occur suddenly or gradually?	Sudden - Gradual
Severity	How severe is the problem?	Mild - Moderate - Severe
Modifying Factors	Is it worse at any specific distance?	Distance - Near - Both
Duration	How long does the problem been occurring?	Short term - Long term
Associated Symptoms	Are there associated symptoms?	No - Headache - Nausea
(Previous Interventions)	Does anything help the problem?	Nothing - Nothing has been tried

Past, family and/or social history **(1, 3)**

Is there anything in your past history, family history or social history which would help us care for you?

- Past History (illnesses, operations, injuries, medications, treatments) [ ] N [ ] Y
- Family History (diseases, hereditary, risk factors, glaucoma, ARMD) [ ] N [ ] Y
- Social History (past and current activities) [ ] N [ ] Y

Do you use any of the following products

Tobacco [ ] N [ ] Y
Alcohol [ ] N [ ] Y
Recreational drugs [ ] N [ ] Y

Occupational Risk

- Do you use a computer more than 30 minutes a day [ ] N [ ] Y

Have you ever been exposed to or infected with:

Gonorrhea	[ ] N	[ ] Y
Hepatitis	[ ] N	[ ] Y
HIV	[ ] N	[ ] Y
Syphilis	[ ] N	[ ] Y

Review of systems - Do you have a problem with ... **(1, 2, 10)**

Eyes	N	Y
Blindness	[ ]	[ ]
Loss of vision	[ ]	[ ]
Distorted vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Flashes or floaters	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]
Chronic eye infections	[ ]	[ ]
Tired eyes	[ ]	[ ]
Halos	[ ]	[ ]
Vision Therapy	[ ]	[ ]
Eye surgery	[ ]	[ ]
Eye injury	[ ]	[ ]
Retinal detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

Allergic/Immunologic	N	Y
Hay fever	[ ]	[ ]
Medicine allergies	[ ]	[ ]
Cancer	[ ]	[ ]
Constitutional symptoms		
fever	[ ]	[ ]
Weight loss	[ ]	[ ]
Cardiovascular		
Heart pain	[ ]	[ ]
High blood pressure	[ ]	[ ]
Vascular disease	[ ]	[ ]
Ears, Nose, Mouth, Throat		
Allergies/Hay fever	[ ]	[ ]
Sinus problems	[ ]	[ ]
Chronic cough	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic ear infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Other glands	[ ]	[ ]
Gastrontestinal		
Diarrhea	[ ]	[ ]
Constipation	[ ]	[ ]
Acid reflex	[ ]	[ ]
Ulcers	[ ]	[ ]
Genitourinary		
Genitals	[ ]	[ ]
Kidneys	[ ]	[ ]
Bladder	[ ]	[ ]

Hematologic/Lymphatic	N	Y
Anemia	[ ]	[ ]
Bleeding problems	[ ]	[ ]
Swelling	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Musculoskeletal		
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle pain	[ ]	[ ]
Joint pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Psychiatric		
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Compulsive behavior	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung cancer	[ ]	[ ]

Review (for office use only) _____, OD