NEURO EYE TEAM

PATIENT INFORMATION FORM

How did you hear about us? _____

Patient's Name:_____

Nickname: _____ Date of birth:_____Gender: ☐Male ☐Female

Address:_____City_____State_____Zip_____

Phone number:_____ Email: _____

Patient's occupation:_____

Patient's employer: _____

Hobbies:_____

Primary reason for today's visit: _____

OCULAR HISTORY

Date of last eye exam:_____ Previous doctor/clinic:_____

Do you have glasses? ☐Yes ☐No If yes, when are they used? ☐Distance ☐Near ☐Both

Do you have contacts? ☐Yes ☐No If yes, what brand (if known)?:_____

Do you ***currently*** have any **eye diseases**?

☐Cataracts ☐Glaucoma ☐Styes ☐Keratoconus ☐Macular degeneration

☐Other (explain):_____

List any eye injuries/surgeries:_____

List any eye drops used and frequency: _____

CURRENT MEDICAL INFO: CHECK Yes / No and CIRCLE or describe any issues that apply.	**Yes**	**No**
Ear, nose, throat problems (sinus, ear infection, chronic cough, dry mouth, etc.) _____	☐	☐
Cardiac / Vascular problems (high blood pressure, heart pain, vascular disease, etc.): _____	☐	☐
Respiratory problems (asthma, emphysema, use of CPAP machine etc.):_____	☐	☐
Gastrointestinal problems (stomach ulcers, reflux, etc.):_____	☐	☐
Genital, kidney or bladder problems:_____	☐	☐
Muscle, bone or joint problems (arthritis, etc.):_____	☐	☐
Skin problems (acne, warts, skin cancer, etc.):_____	☐	☐
Neurological problems (multiple sclerosis, migraines, seizures, etc.):_____	☐	☐
Psychiatric / social problems (anxiety, depression, bipolar, insomnia, etc.): _____	☐	☐
Endocrine problems (diabetes, thyroid disorder, pituitary tumor, etc.): _____	☐	☐
Blood/lymphatic problems (high cholesterol, anemia, etc.): _____	☐	☐
Allergic/immune problems (hay fever, lupus, Sjogrens, etc.): _____	☐	☐
Other:_____	☐	☐

PLEASE TELL US IF YOU HAVE EVER… (Please answer and describe):	**Yes**	**No**
Sustained a head injury or trauma/stroke?_____	☐	☐
Been in a car accident? _____	☐	☐

Been diagnosed with Autism or Spectrum Disorder? _____ ☐ ☐
Been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD): _____ ☐ ☐
Been diagnosed with a learning disability or developmental disorder? _____ ☐ ☐
Had any surgeries? _____ ☐ ☐
Been diagnosed with cancer? What type? _____ ☐ ☐

ADDITIONAL MEDICAL INFORMATION

Primary Care Physician's Name:_____ Clinic:_____
Last visit:_____
What is your current height? _____feet _____ inches. What is your current weight? _____ pounds
Are you pregnant or nursing? ☐Yes ☐No If yes, when is due/birth date? _____
Has a neurological evaluation ever been performed? ☐Yes ☐No
If yes, name and contact: _____
List any medications you are allergic to:_____
List all prescription medications, vitamins, supplements, and over-the-counter medications you are taking:

Medicine	Dosage/ Frequency	Reason

GENERAL HEALTH AND LIFESTYLE INFORMATION

How often do you use tobacco products?
☐Never ☐Daily (>10/day) ☐Daily (<10/day) ☐Sometimes, not daily ☐Former smoker
How often do you drink alcohol? _____
How often do you use recreational drugs?_____
How many hours a day do you spend on screens (cellphone, tablet, computer, television)?_____
Which of the following describes your diet?
☐Excellent, a wide variety of foods are eaten from each food group daily
☐Good, some items from each food group are apart of my weekly diet
☐Poor, I only eat a select amount of foods and do not often eat from multiple food groups

Please circle all that apply to how you feel the majority of the time?
☐Fatigue ☐Average energy level ☐High energy ☐Relaxed ☐Impulsive
☐Irritable ☐Happy ☐Tense ☐Frustrated ☐Anxious ☐Depressed

FAMILY MEDICAL HISTORY

Do your ***family members*** (grandparents, parents, siblings) have any of the following conditions?

	Yes	**No**	If so, who? M=mother, F=father, S=sibling, GP=grandparent
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____

Cataracts ☐ ☐ _____
Macular degeneration ☐ ☐ _____
Eye turn (strabismus) ☐ ☐ _____
Lazy eye (amblyopia) ☐ ☐ _____
Retinal detachment ☐ ☐ _____
Rheumatoid arthritis ☐ ☐ _____
Cancer ☐ ☐ _____
Diabetes ☐ ☐ _____
High blood pressure ☐ ☐ _____
Stroke ☐ ☐ _____
Heart disease ☐ ☐ _____

VISION SYMPTOMS:

Do you ***currently*** have any **vision-related issues**?

☐Blurred vision ☐Double vision ☐Motion sickness/ car sickness
☐Loss of vision ☐Flashes in vision ☐Discomfort with 3D movies
☐Floaters in vision ☐Blind spots ☐Poor reading comprehension
☐Eye turn ☐Lazy eye ☐Poor tracking / eye movements
☐Halos in vision ☐Light sensitivity ☐Head tilt / face turn. ☐Lose attention easily

Do you ***currently*** have any **eye comfort-related issues**?

☐Dry eye ☐Burning eyes ☐Tired eyes
☐Eye pain ☐Eye soreness ☐Watery eyes
☐Itchy eyes ☐Gritty/ sandy feeling ☐Mucous discharge
☐Red eyes ☐Other: _____

Do you ***currently*** have any **motor-related issues**?

☐Poor motor control ☐Clumsy/ stumble easily
☐Trouble sitting still ☐Balance Issues
☐Trouble catching a ball

Do you ***currently*** have any neurological symptoms?

☐Severe lethargy ☐Vertigo ☐Severe neck stiffness
☐Speech difficulties ☐Fainting or light-headness ☐Vomiting during the night or upon waking
☐Persistent hemifacial or hemicranial pain, numbness, pins and needles

Vision Symptoms Survey

Please check the most appropriate box or circle the item number that best matches your observations. All information will be held in confidence. **0: Never 1: Seldom 2: Occasionally 3: Frequently 4: Always**

EYESIGHT CLARITY					
Distance vision blurred and not clear (even with lenses)	0	1	2	3	4

Near vision blurred and not clear (even with lenses)	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision/ can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort/ sore eyes/ eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue/ very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
HEADACHES					
Frequency	0	1	2	3	4
Severity	0	1	2	3	4
Location?					
Do they wake you up at night?					
Do you experience migraines?					
DOUBLING					
Double vision (especially when tired)	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable- too much glare	0	1	2	3	4
Outdoor light too bright - have to use sunglasses	0	1	2	3	4
Indoor fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Rub eyes a lot	0	1	2	3	4

Vision Symptoms Survey Continued

Please check the most appropriate box or circle the item number that best matches your observations. All information will be held in confidence. **0: Never 1: Seldom 2: Occasionally 3: Frequently 4: Always**

DEPTH PERCEPTION					
Clumsiness/ misjudge where objects really are	0	1	2	3	4

Lack of confidence walking/ missing steps/ stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted/ objects move or change position	0	1	2	3	4
What looks straight ahead, isn't always straight ahead	0	1	2	3	4
Avoid crowds/ can't tolerate "visually-busy" places	0	1	2	3	4
Loss of field of vision?	0	1	2	3	4
READING					
Short attention span/ easily distracted when reading	0	1	2	3	4
Difficulty/ slowness with reading and writing	0	1	2	3	4
Poor reading comprehension/ can't remember what was read	0	1	2	3	4
Confusion of words/ skip words during reading	0	1	2	3	4
Lose place/ have to use finger not to lose place when reading	0	1	2	3	4

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between the patients and the practice, we have adopted the following financial policy. If you have any questions, please feel free to ask management. Our goal is to provide the best possible care for you and your family. A complete understanding of the financial policies below will help us to uphold that goal.

- Neuro Eye Team is an in-network provider for patients who have traditional Medicare as a primary insurance. We are an out-of-network provider for all patients that do not have primary coverage through traditional Medicare. Out-of-network patients must provide payment at the time of service. Medicare patients must provide deductible and/or co-insurance payments at the time of service. Furthermore, Medicare patients must provide payment for services that are not covered by traditional Medicare insurance at the time of service. For your convenience we accept cash, check, and credit/debit card.
- As a courtesy, Neuro Eye Team can file claims towards a patient's out-of-network benefits on behalf of the patient. Neuro Eye Team will collect full payment at the time of service. Your insurance provider will process your claim and determine your eligibility based on your out-of-network benefits. If found eligible, your insurance provider will either apply your payment to your insurance deductible or send you a reimbursement check in the mail. Your insurance policy is a contract between you and your insurance provider. Neuro Eye Team is not responsible for discussing or negotiating your benefits for reimbursement with your policy holder. In the event that your insurance determines the service is "not covered", you will not be eligible for a reimbursement check. It is up to the patient to investigate coverage further with their insurance company.
- Non-Medicare patients can opt-out of having claims submitted towards their out-of-network benefits. Please initial below if you would like to opt-out of an out-of-network claim.
- We offer Care Credit as another payment option. It is a convenient, low minimum monthly payment program (6 months deferred interest) specifically designed to pay for healthcare and elective treatment not covered by insurance. Please ask us for more information or how to sign up.
- Neuro Eye Team offers in house financing plans for individuals that do not qualify for Care Credit and do not have the financial ability to meet the full cost of services up front. Individuals who feel they qualify for this may fill out the financial aid application to determine qualification based upon household/family size and annual income. If your application is approved, a payment plan will be made and honored for the service that you applied before. Approval must be granted per service and patients may be asked to re-submit documentation per new calendar year.
- We will look to the guardian of the minor for consent and financials regarding any and all services rendered.
- There will be a $25 returned check fee for any checks returned by the bank.

My signature below confirms that I understand the above policies and that I am responsible for payment at the time of service.

Patient's Printed Name:_____

Patient/Guardian Signature and Date:_____

M

y initial signifies that I am a non-Medicare patient and would like to opt-out of an out-of-network claim. Therefore, I do NOT want Neuro Eye Team to submit a claim to my insurance provider:

_____ (Patient's Initials)

RELEASE OF INFORMATION

I agree to permit information from my examination records, or copies of my records, to be forwarded to other healthcare providers or insurance carriers upon written request or upon the recommendation of Alex Conley, O.D. when it is necessary for the treatment of my visual condition, my treatment process with Neuro Eye Team, or the processing of insurance claims.

Patient's Printed Name:_____

Patient/Guardian Signature and Date:_____