Appointment Checklist

- Current health insurance information, including ID card
- Photo identification
- Completed registration forms. They may be filled in online but must be printed.

  The check-in time is when the patient presents completed registration forms, not when the patient arrives. Please arrive 20-30 minutes prior to the appointment time if forms need to be completed in the office.
- Referral/Authorization (if required by your insurance)
- List of all medications you are taking (including strengths/dosages)
- Pharmacy information (name, address, and phone number)
- Please bring a translator, if necessary.
- Copays and other out of pocket expenses will be collected at check-in. We accept cash, check, and most credit cards.
- Glasses and/or contact lenses (Please bring contact lens boxes with lens information.)
- If relevant, please bring records pertaining to your condition such as relevant MRI/CT results, labwork, operative reports, etc.
- Please allow sufficient travel time. If you arrive more than 20 minutes after your scheduled appointment time, you may be asked to reschedule.

Ideal EyeCare * 6028 S. Fort Apache Road, Suite 101 * Las Vegas, NV 89148

Ideal EyeCare Registration Form

Name:		Home Phone:	
Date of Birth:	Age:	Mobile Phone:	
SSN:		Email:	
Gender: M F		May we contact you by:	□ Phone □ Text □ Email □ All (check preferred contact methods)
Street Address:			
City, State, Zip Code:			
Race: □ Alaskan □ American Indian □ Asian □ Black □ Hawaiian/Pac Islander □ Spanish/Latin □ White □ Other_____			
Ethnicity:		Preferred Language:	
Employer:			
Pharmacy:		Phone #:	Cross Streets:
Referring Physician:		Phone #:	
Primary Care Physician:		Phone #:	
Emergency Contact:		Phone #:	

Insurance Information

Primary:	Secondary:
ID #:	ID #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Co-Pay:	Co-Pay:

HIPAA Approved Contacts

Last Name	First Name	Middle	Gender	Date of Birth	SSN	Relationship
Address	City	State	Zip Code	Home	Cell	Work
Last Name	First Name	Middle	Gender	Date of Birth	SSN	Relationship
Address	City	State	Zip Code	Home	Cell	Work

Patient's or Authorized Person's Signature

I, the undersigned give authorization to assign directly to Grace S. Shin, MD, LTD, all medical benefits, including any payable to me for services rendered. I understand I am ultimately financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Shin to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand payment is expected at the time of service.

Signature: _____ **Signature Date:** _____

Parent/Guardian Signature: _____**Signature Date:** _____

We also offer a multitude of aesthetic services!

Whether your concerns are fine lines and wrinkles, facial volume loss, body contouring, brown spots or pigment, acne treatment/prevention, and/or tattoo removal, we have advanced solutions available for every skin type.

☐ **Yes, I would like more information.** ☐ **No, thank you. I am not interested.**

Ideal EyeCare Medical History Questionnaire

Name: _____Date of Birth: ____/____/_____ Last Eye Exam: ____/____/____

Primary Care Physician: _____ Referring/Specialty Dr.:_____

Do you wear glasses? □ Yes □ No **Do you wear contact lenses?** □ Yes □ No

Reason for today's visit: _____

Are you <u>currently</u> experience any of the following: (Please mark all that apply)							
Abnormal Head Position		Dry Eyes		Flashes of light/Floaters		Itchy Eyes/Lids	
Blurry/Decreased Vision		Eye Injury		Glare/Light Sensitivity		Red Eye(s)	
Double Vision		Eye Pain/Burning		Growth/Bump in Lid		Watery Eyes	
Droopy Lid		Eye Misalignment		Headaches		Other_____	
Past Ocular History: (Please mark all that apply)							
NONE		Cataract(s)		Hyperopia (Farsightedness)		Myopia (Nearsightedness)	
Amblyopia (Lazy Eye)		Diabetic Retinopathy		Iritis		Optic Neuritis	
Aphakia		Dry Eyes		Keratoconus		Retinal Detachment	
Astigmatism		Glaucoma		Macular Degeneration		Other_____	
Ocular Surgeries: (Please mark all that apply)							
NONE		Foreign Body Removal		Retinal Laser		Trabeculotomy/ectomy	
Blepharoplasty		LASIK/PRK/RK		RD Repair			
Cataract Surgery		Ptosis Repair		Strabismus Surgery (Eye Muscle Surgery)		Vitrectomy	
Corneal Transplant		Punctal Plugs				Other_____	
Ocular Significant Illnesses/Conditions: (Please mark all that apply)							
NONE		Diabetes		Hypertension		Parkinson's Disease	
Bell's Palsy		Headaches/Migraines		Hyperthyroidism		Rheumatoid Arthritis	
Brain Tumor		Herpes Simplex		Meningitis		Stroke/TIA	
Cancer		Histoplasmosis		Myasthenia Gravis		Syphilis	
Chicken Pox/Shingles		HIV+/AIDS		Multiple Sclerosis		Other_____	
Other Past Medical Illnesses/Surgical Procedures: (Please mark all that apply)							
NONE		Depression		Irregular Heart Beat		Polymyalgia	
Anemia		Eczema		Kidney Disease		Psychiatric Disorder	
Asthma		Hearing Loss		Lung Disease		Seizures	
CHF		Heart Attack		MRSA		Skin Cancer	
COPD/Emphysema		Hypothyroidism		Osteoarthritis		Other_____	
Family History: (Please mark all that apply)							
Blindness		Eye Misalignment		Hyperthyroidism		Retinal Detachment	
Cancer		Glaucoma		Lazy Eye (Amblyopia)		Strabismus	
Cataracts		Heart Disease		Macular Degeneration		Stroke	
Diabetes		High Blood Pressure		Migraines		Other_____	

Please continue on the back side of this page →

Allergies: (Please list known drug/environment/food allergies you have)		
Latex		**Other**:_____
Penicillin		_____
Systemic Medications: (Please list all OTC/supplements/prescription medications you take, including strengths/dosages)		
Please see list provided (Please provide list on separate page)		
Ocular Medications: (Please list all eye medications you take including strengths/dosages)		
General Surgeries/Operations: (Please include dates performed and request separate page if necessary)		

Social History:					
Do you smoke? Y N ____ Packs/Day			**Have you ever smoked?** Y N		
Do you drink alcohol? Y N ____glasses/bottles per day/week			**Drug Use:** Y N Substance:_____		
Occupation: _____			Frequency: Daily Weekly Occasionally		
Race:	Hispanic		Non-Hispanic		No Answer	
Ethnicity:	Asian		Caucasian		American Indian/Alaskan	
Other:	Hawaiian/Pacific Islander		Black/African American		Unknown	

Review of Systems

EDIT

Eyes *	Normal	**Respiratory** *	Normal	**Blood/Lymphnodes** *	Normal
Previous Surgery ☐ YES ☐ NO		Cough ☐ YES ☐ NO		Easy Bruising ☐ YES ☐ NO	
Contact Lens ☐ YES ☐ NO		Congestion ☐ YES ☐ NO		Gums Bleed Easily ☐ YES ☐ NO	
Pain ☐ YES ☐ NO		Wheezing ☐ YES ☐ NO		Prolonged Bleeding ☐ YES ☐ NO	
Double Vision ☐ YES ☐ NO		Asthma ☐ YES ☐ NO		Heavy Asprin Use ☐ YES ☐ NO	
Glaucoma ☐ YES ☐ NO		Shortness of Breath ☐ YES ☐ NO		Blood Clots ☐ YES ☐ NO	
Cataracts ☐ YES ☐ NO				Swollen Glands ☐ YES ☐ NO	
Macular Degeneration ☐ YES ☐ NO		**Gastrointestinal** *	Normal	**MusculoSkeletal** *	Normal
Dry Eyes ☐ YES ☐ NO		Heartburn ☐ YES ☐ NO		Stiffness ☐ YES ☐ NO	
Blurry Vision ☐ YES ☐ NO		Nausea/Vomiting ☐ YES ☐ NO		Arthritis ☐ YES ☐ NO	
Eye pain/burning ☐ YES ☐ NO		Jaundice/Hepatitis ☐ YES ☐ NO		Joint Pain/Swelling ☐ YES ☐ NO	
Flashes of Light/Floaters ☐ YES ☐ NO		Abdominal Pain ☐ YES ☐ NO		Back Pain ☐ YES ☐ NO	
Glare/Light Sensitivity ☐ YES ☐ NO		Diarrhea ☐ YES ☐ NO		Weakness ☐ YES ☐ NO	
Ear, Nose, and Throat *	Normal	**Genito-Urinary** *	Normal	**Skin** *	Normal
Hard of Hearing ☐ YES ☐ NO		Pain/Difficulty ☐ YES ☐ NO		Rash/Sores ☐ YES ☐ NO	
Ringing in Ears ☐ YES ☐ NO		Blood in Urine ☐ YES ☐ NO		Lesions ☐ YES ☐ NO	
Vertigo ☐ YES ☐ NO		History of Kidney Stones ☐ YES ☐ NO		Hives/Eczema ☐ YES ☐ NO	
Cold Sores ☐ YES ☐ NO		History of STD's ☐ YES ☐ NO		Cafe-au-lait Spots ☐ YES ☐ NO	
Dry Mouth ☐ YES ☐ NO		Discharge ☐ YES ☐ NO			
Cardiovascular *	Normal	Urinary Incontinence ☐ YES ☐ NO		**Neurological** *	Normal
Chest Pain ☐ YES ☐ NO		**Psychiatric** *	Normal	Seizures ☐ YES ☐ NO	
Dizziness ☐ YES ☐ NO		Anxiety/Depression ☐ YES ☐ NO		Weakness/Paralysis ☐ YES ☐ NO	
Fainting Spells ☐ YES ☐ NO		Mood Swings ☐ YES ☐ NO		Numbness ☐ YES ☐ NO	
Shortness of Breath ☐ YES ☐ NO		Difficulty Sleeping ☐ YES ☐ NO		Tremors ☐ YES ☐ NO	
Irregular Heart Beat ☐ YES ☐ NO					
Difficulty Lying Flat ☐ YES ☐ NO					
Leg Swelling ☐ YES ☐ NO		**Endocrine** *	Normal	**Immunologic** *	Normal
Palpitations ☐ YES ☐ NO		Increased Thirst ☐ YES ☐ NO		Hives ☐ YES ☐ NO	
Constitutional *	Normal	Increased Hunger ☐ YES ☐ NO		Itching ☐ YES ☐ NO	
Fatigue/Weakness ☐ YES ☐ NO		Increased Urination ☐ YES ☐ NO		Runny Nose ☐ YES ☐ NO	
Fever ☐ YES ☐ NO		Increased Sweating ☐ YES ☐ NO		Sinus Pressure ☐ YES ☐ NO	
Weight Gain/Loss ☐ YES ☐ NO		Fingernail Changes ☐ YES ☐ NO			

Financial Policy

The following information is regarding your account at Ideal EyeCare. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent care for all of your eye care needs.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan since they constantly change. We cannot be held liable for misquoted benefits or eligibility.
- The determination of your best corrected vision is called a ***refraction*****.** This is considered a **non-covered service/procedure** by most insurance companies. You will be responsible for the **$55.00** fee when this service is performed. We will bill this service to your insurance as a courtesy, and if they pay any portion, you will be refunded their payment amount.
- For those patients being followed for strabismus, a sensorimotor examination will be performed at each visit. This service is separate from the office visit and may be considered a diagnostic test by your insurance, resulting in additional out-of-pocket cost to you.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- All "self pay" patients are required to pay in full at the time services are rendered. We will extend a 20% prompt-pay cash discount on all professional services and provide you with an itemized receipt.
- Our office does **not** accept insurance liens, workers compensation, or attorney liens. Payment is the patient's responsibility and due in full at the time of service.
- All returned checks are subject to a $35.00 processing fee and will result in refusal to accept future payments by check.
- If the parents are divorced, the parent bringing the child for treatment is ultimately responsible for payment, regardless of the terms of any divorce decree or custody arrangement.
- All outstanding balances must be paid in full before scheduling surgery, except in emergent cases.
- All delinquent accounts may be sent to a collection agency and you may be charged any/all applicable collection fees. Once an account has been transferred to collections, you ***and*** your immediate family members will be **discharged** from the practice.
- Any account credit balance less than $2.00 will not be issued a refund check.
- We will charge a $25.00 per page fee for any and all forms that require the doctor's signature and review. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- A **$50.00** fee will be charged for all **NO SHOW** or missed appointments that are not cancelled within 24 hours of your scheduled appointment. This amount will be required before your next scheduled appointment. As a courtesy to all patients, we will try to notify you with a reminder call 48 hours prior to your visit. It is very important that you keep the front desk updated with your most current information.

I understand that even if Ideal EyeCare is contracted with my health care plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Ideal EyeCare for services rendered and request that Ideal EyeCare submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

_____ _____

Patient Signature/Legal Guardian Signature **Date**

_____ _____

Please Print Patient's Name **Date**

Thank you for choosing Ideal EyeCare!