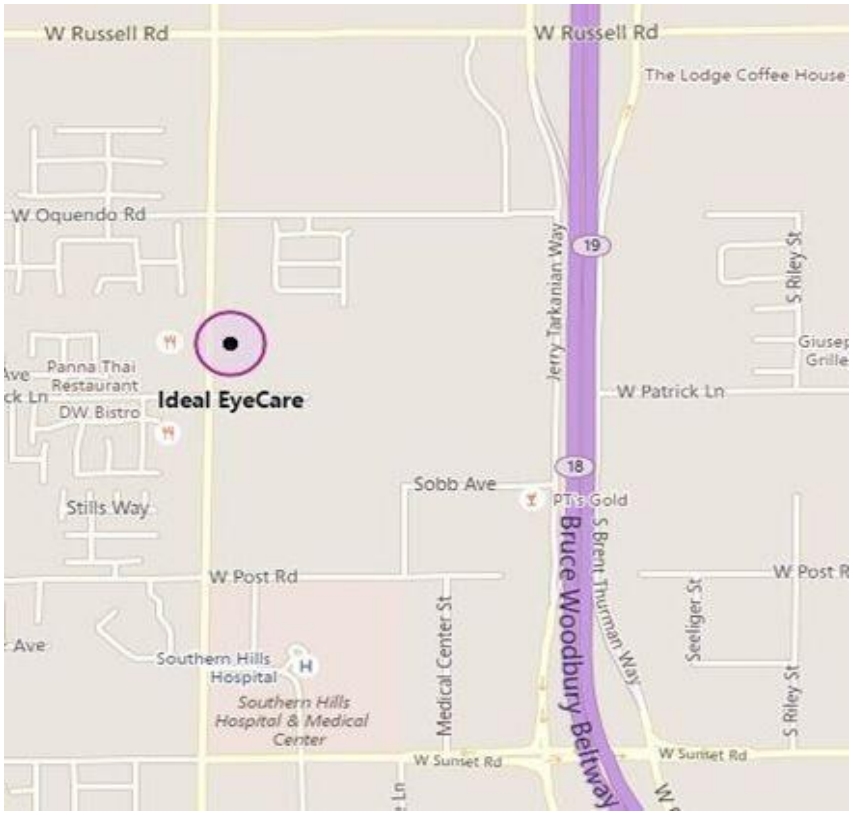
APPOINTMENT CHECKLIST-ADULT

- 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 your appointment time if forms need to be completed in the office.
- Referral/Authorization (if required by your insurance)
- List of all medications/supplements you take (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, lab results, etc. If you have had strabismus surgery, please obtain a copy of the operative report from the surgeon and bring it to your appointment.
- Please allow sufficient travel time. If you arrive more than 20 minutes after your scheduled appointment time, you may be asked to reschedule.
- Your initial evaluation may take several hours, please plan accordingly.



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

THANK YOU FOR CHOOSING IDEAL EYECARE

Ideal EyeCare Registration Form-Adult

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

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name:	Insurance Name:
ID #:	ID #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Date of Birth:	Subscriber Date of Birth:

HIPAA Approved Contacts

Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:

Patient's or Authorized Person's Signature

I understand that even if Ideal EyeCare is contracted with my insurance plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I understand that any payment collected today is an *estimate* of my total liability and additional monies may still be owed once my insurance plan has processed the claim. I request payment of authorized benefits by my insurance plan be made 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 the release of any/all medical information to the insurance carrier or its agents to allow for benefit or claim determination. I understand that if Ideal EyeCare does not participate with my insurance plan or if I have elected to receive care outside of my insurance coverage, I am assuming financial responsibility for all services rendered and no claim will be filed to my insurance company on my behalf. I certify that the information provided above is complete and accurate and assume any and all financial liability caused by omissions or inaccuracies.

Signature: _____ **Date:** _____

Signature of Legal Guardian:_____ **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 OPHTHALMOLOGY

MEDICAL HISTORY QUESTIONNAIRE-ADULT

Name:_____ **Date of Birth:**_____ **Today's Date:** _____

Primary Care Doctor: _____ **Referring Doctor/Specialist:** _____

What is the reason for today's visit?_____

Do you need to renew your Drivers License within the next 90 days? □ Yes □ No

If you wear glasses, what is your preferred type? (Please mark all that apply)

□ Distance only □ Reading Only □ Computer Only □ Bifocals □ Trifocals

□ Progressives (no line bifocal) □ Rx Sunglasses □ Non-Rx Sunglasses

Do you wear contact lenses? □ Yes □ No **Are you interested in contact lenses?** □ Yes □ No

Allergies	**Reaction**	**Severity**
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe

Are you *currently* experiencing any of the following: (Please mark all that apply and provide detail)

□ Abnormal Head Position_____
□ Blurry/Decreased Vision _____
□ Double Vision _____
□ Droopy Eyelid(s) _____
□ Dry Eyes _____
□ Eye Injury _____
□ Eye Pain/Burning _____
□ Eye Misalignment _____
□ Flashes/Floaters _____
□ Glare/Light Sensitivity_____
□ Growth/Bump in Lid _____
□ Headaches _____
□ Itchy Eyes/Eyelids _____
□ Red Eyes _____
□ Watery Eyes _____
□ Other _____
□ **NONE** (I am not experiencing any of these symptoms)

Past Ocular History: (Please mark all that apply and provide detail) □ **NONE** (I have never had any of these conditions)

□ Amblyopia (Lazy Eye)_____
□ Aphakia _____
□ Astigmatism _____
□ Cataracts _____
□ Diabetic Retinopathy_____
□ Dry Eyes _____
□ Glaucoma _____
□ Hyperopia (Farsightedness)_____
□ Iritis/Uveitis _____
□ Keratoconus_____
□ Macular Degeneration (Dry)_____
□ Macular Degeneration (Wet)_____
□ Myopia (Nearsightedness)_____
□ Optic Neuritis_____
□ Retinal Detachment_____
□ Other _____

Past Ocular Surgeries: (Please mark all that apply and provide detail)

□ Blepharoplasty_____
□ Cataract Surgery_____
□ Corneal Transplant _____
□ Foreign Body Removal_____
□ LASIK/PRK/RK_____
□ Ptosis Repair_____
□ Punctal Plugs_____
□ Retinal Laser_____
□ RD Repair_____
□ Strabismus Surgery_____
□ Glaucoma Surgery_____
□ Vitrectomy_____
□ Other_____
□ **NONE** (I have never had eye surgery)

WOMEN: Are you pregnant or nursing? □ Yes □ No

MEN: Have you ever taken prostate medicines / alpha blockers? □ Yes □ No If yes, please mark which medication(s):

□ Flomax □ Tamsulosin □ Hytrin □ Cardura □ Saw Palmetto □ Doxazosin □ Terazosin □ Uroxatral □ Rapaflo

Preferred Pharmacy (Name & cross-streets)_____

Systemic Medications: (Please list all OTC/supplements/Prescription Medications you take inc dosage/strength)

□ Please see Medication List (separate page) □ **NONE** (I do not take medications (OTC or RX)/vitamins/supplements)

_____

_____

_____

_____

Ocular Medications: (Please list **all** OTC/supplements/Rx medications, inc. dosage/strength-or attach a separate page)

_____

_____

Please continue on the back side of this page →

Ocular Significant Illnesses/Conditions: (Please mark all that apply and provide detail)

□ Bell's Palsy_____
□ Brain Tumor_____
□ Cancer _____
□ Chicken Pox/Shingles_____
□ Diabetes _____
□ Type I □ Type II □ Diet-Controlled □ Insulin Use □ Oral Medication(s) Use Last Hemoglobin A1C_____ Date_____
Average BSL _____ Name of doctor who manages your diabetes (Internist/Endocrinologist)_____
□ Headaches/Migraines_____
□ Herpes Simplex_____
□ Histoplasmosis _____
□ HIV/AIDS _____
□ Hypertension_____
□ Meningitis _____
□ Myasthenia Gravis_____
□ Multiple Sclerosis_____
□ Parkinson's _____
□ Rheumatoid Arthritis_____
□ Stroke/TIA_____
□ Syphilis_____
□ Thyroid disease_____
□ Other:_____
□ **NONE** (I have never had any of these conditions)

Other Past Medical Illnesses (Please mark all that apply and provide detail)

□ Anemia_____
□ Asthma_____
□ CHF_____
□ COPD/Emphysema_____
□ Depression_____
□ Eczema_____
□ Hearing Loss_____
□ Heart Attack (MI)_____
□ Irregular Heartbeat (Arrhythmia)_____
□ Kidney Disease_____
□ Lung Disease_____
□ MRSA_____
□ Osteoarthritis _____
□ Polymyalgia_____
□ Psychiatric Disorder_____
□ Seizure Disorder_____
□ Skin Cancer_____
□ Sleep Apnea_____
□ Other_____
□ Other_____
□ **NONE** (I have never had any of these conditions)

Other Systemic Surgeries/Operations: (Please include dates performed and request separate page if necessary)

□ Please see Procedure List (separate page) □ **NONE** (I have never had any type of surgery or procedure)

_____
_____
_____

Family History (Please mark all that apply and circle which family member) □ **Unknown Family History**

□ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Cataracts	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Strabismus	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Amblyopia (Lazy Eye)	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Hypertension	Parent / Sibling / Maternal Grandparent / Paternal Grandparent

Social History:

Do you smoke/vape tobacco? □ Yes □ No If yes, how much and how often?_____
Have you ever smoked tobacco? □ Yes □ No Do you use other tobacco products? □ Yes □ No
Do you drink alcohol? □ Yes □ No If yes, how much and how often?_____
Do you use recreational drugs? □ Yes □ No If yes, what substance and how often?_____

Are you bothered by Dry Eyes? Please indicate which symptoms you experience:

□ Burning □ Eye Fatigue □ Gritty/Sandy sensation □ Soreness □ Irritation □ Watery eyes

Do you use artificial tears? □ Yes □ No **What brand and how often?** _____

Do you use Restasis, Cequa, or Xiidra regularly? □ Yes □ No

Have you received any of these treatments?:

□ Punctal Plugs □ LipiFlow □ Autologous blood serum drops □ IPL (Intense Pulsed Light) □ Prokera graft □ iLux □ BlephEx

I have completed this form as accurately as possible. I understand that providing incorrect information or omitting information can be dangerous to my health and it is my responsibility to inform the office of any changes in my health status.

Signature: _____ **Date:** _____

REVIEW OF SYSTEMS (Please check any/all symptoms/conditions you *currently* experience)

Ears, Nose, and Throat
- □ Hearing Impairment
- □ Ringing in Ears
- □ Vertigo
- □ Cold Sores
- □ Dry Mouth
- □ Sinusitis

Cardiovascular-Heart
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heartbeat (arrhythmia)
- □ Atrial Fibrillation
- □ Difficulty Lying Flat
- □ Leg Swelling
- □ Palpitations
- □ Blood Clots (DVT)
- □ High Cholesterol

Constitutional
- □ Fatigue/Weakness
- □ Fever
- □ Weight Gain/Loss

Respiratory-Breathing
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma
- □ Shortness of Breath
- □ Emphysema
- □ Tuberculosis
- □ Sleep Apnea
  - □ CPAP with Oxygen
  - □ CPAP without Oxygen

Gastrointestinal Disease-Stomach
- □ Acid Reflux/Heartburn
- □ Nausea/Vomiting
- □ Jaundice/Hepatitis
- □ Abdominal Pain
- □ Diarrhea
- □ Colitis-Ulcerative
- □ Diverticulitis/Diverticulosis
- □ Gastric Stomach Ulcer
- □ Hiatal Hernia
- □ Irritable Bowel Syndrome (IBS)
- □ Crohn's Disease

Genitourinary
- □ Pain/Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD
- □ Discharge
- □ Urinary Incontinence
- □ Chronic Dialysis
- □ Enlarged Prostate
- □ Renal Failure
- □ Uterine Disease

Psychiatric
- □ Anxiety
- □ Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes
- □ Temperature Intolerance

Hematologic/Lymphatic (Blood)
- □ Easy Bruising
- □ Gums Bleed Easily
- □ Prolonged Bleeding
- □ Heavy Aspirin Use
- □ Blood Clots
- □ Malignant Hyperthermia
- □ Liver Disease

Musculoskeletal (Muscles, joints, & bones)
- □ Stiffness
- □ Arthritis
- □ Joint Pain
- □ Joint Swelling
- □ Back Pain
- □ Weakness
- □ Gout
- □ Osteoporosis
- □ Osteopenia

Integumentary (Skin)
- □ Rash
- □ Sores
- □ Lesions
- □Hives
- □ Eczema
- □ Café-au-lait spots
- □ Psoriasis
- □ Rosacea

Neurological
- □ Seizures
- □ Weakness/Paralysis
- □ Numbness
- □ Tremors
- □ ADHD/ADD
- □ Alzheimer's
- □ Dementia
- □ Cerebral Palsy
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Parkinson's Disease
- □ Fibromyalgia
- □ Mini Strokes (TIA)
- □ Stroke (CVA)
- □ Memory Loss
- □ Hallucinations

Immunologic/Inflammatory
- □ Hives
- □ Seasonal Allergies
- □ HIV
- □ AIDS
- □ Lupus erythematous
- □ Myasthenia Gravis
- □ Rheumatoid Arthritis
- □ Sarcoidosis
- □ Celiac Disease
- □ Hepatitis
  - □ Type A
  - □ Type B
  - □ Type C
  - □ Type D
  - □ Type E
  - □ Other:_____
- □Guillain-Barre Syndrome
- □ Sjogren's Syndrome
- □ Temporal Arteritis
- □ Ankylosing Spondylitis

History of Infectious Disease (Latent)
- □ Chicken Pox (Varicella)
- □ Shingles
- □ MRSA
- □ Meningitis
- □ Tuberculosis

Genetic Disorders
- □ Chromosomal Abnormality
- □ Syndrome: _____
- □ Retinitis Pigmentosa
- □ Down Syndrome
- □ Other: _____

Cancer
- □ Bladder
- □ Breast
- □ Colon
- □ Hodgkin's Lymphoma
- □ Non-Hodgkin's Lymphoma
- □ Prostate
- □ Skin
  - □ Basal Cell
  - □ Squamous Cell
  - □ Melanoma
- □ Leukemia
- □ Lung
- □ Lymphoma
- □ Ovarian
- □ Thyroid
- □ Uterine
- □ Cervical
- □ Other: _____

Treatment Type:
- □ Surgery: _____
- □ Radiation: _____
- □ Chemotherapy: _____

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 and attorney 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 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 our office 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 Name:_____ **Date:**_____

Signature of Patient/Legal Guardian:_____ **Date:**_____