

Welcome to Moderne Eye Optometry

Are you a returning patient? Y/N

Name (First, Middle, Last) _____ Date _____

Address _____ Birth Date _____

City _____ State _____ Zip code _____ Last 4 Digits SSN _____

Employer _____ Occupation _____

Moderne Eye would like to communicate information via text, email and voicemail regarding your appointment, prescriptions and promotions. Please provide us with phone numbers and emails for this purpose.

() _____ cell () _____ home

() _____ work _____ Email _____

Referred by _____ Last examination _____ By whom? _____

Are you interested in new **glasses/contact lenses/both?** (Circle)

Any specific eye concerns at this time? _____

Emergency Contact/Relation _____ Telephone no. _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____ Year _____

Have you had an eye injury? Y/N Kind _____ Year _____

Do you have glaucoma? Y/N Cataracts? Y/N Macular Degeneration? Y/N

Blurred vision? Y/N Dry eyes? Y/N Do you nap in contacts? Y/N

Other eye problems? Y/N What kind? _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems? (Please circle all that apply)

Eyes Y/N Ear/Nose/Throat Y/N Cardiovascular Y/N

Gastrointestinal Y/N Nervous Y/N Mental Y/N

Respiratory Y/N Genitourinary Y/N Endocrine (glands) Y/N

Musculoskeletal Y/N Blood/Lymph Y/N Skin Y/N

Allergic/immunological Y/N High Blood Pressure Y/N Diabetes Y/N

If yes, please explain: _____

Name of family doctor: _____ Last exam? _____

List current medications? _____

Medication allergies? Y/N Allergic to? _____ What happens? _____

Surgical operations? Y/N What kind? _____ Date _____

Seasonal Allergies? Y/N To what? _____ What happens? _____

Do you use: cigarettes/tobacco? Y/N Alcohol? Y/N

FAMILY HISTORY

Hypertension: Y/N Who? _____ Diabetes: Y/N Who? _____

Retinal Detachment: Y/N Who? _____ Glaucoma: Y/N Who? _____

Unexplained blindness: Y/N Who? _____ Other eye conditions Y/N Who? _____

CONTACT LENS PRESCRIPTIONS

If you wish to update your contact lens prescription or be refit into new contact lenses, a contact lens evaluation or refitting fee will be charged, as these services are not included in the general eye examination fee. By accepting a trial pair of contact lenses, you agree that a follow-up visit is required to finalize a new contact lens fitting. A contact lens prescription can be released only after appropriate follow-up visits have been completed. Contact lens prescriptions are valid for one year.

SPECTACLE PRESCRIPTION WARRANTY

If you have any questions about your new glasses, please see our optician to verify the adjustment of the glasses and for further demonstration of the optics of specialty lenses. The examining optometrist, at no additional cost, can verify your spectacle prescription within 60 days of the original eye examination.

FRAME POLICY

New frames purchased at Moderne Eye Optometry may be warranted by the frame manufacture for **defects**. Frames that are being reused or purchased elsewhere are not guaranteed from any breakage or damage during the lens replacement process or adjustments.

PAYMENT AND CANCELLATION POLICY

Payment for materials and services are due when services are rendered. We require payment in full for materials in advance of processing an order (this includes all extra charges not covered by vision plans). If you chose to cancel your prescription spectacle or contact lens order after your payment has been made, a 50% cancellation fee will be charged to cover our services. Orders will not be placed without payment in advance. If you have any questions, please ask.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review and/or have received a copy of Moderne Eye Optometry's Notice of Privacy Practices.

Signature: _____ Date: _____

NPP REV. B

INSURANCE/FINANCIAL RESPONSIBILITY

Vision Service Plan Cigna Blue Cross Blue Shield Medicare Other None

Advance Beneficiary Notice:

I authorize Moderne Eye Optometry to submit my claim to VSP/Medicare for eye care and materials services rendered. Depending on the benefits selected by your employer, your plan may not pay for a particular service or material. This does not mean that you should not receive these services or materials. We will provide an explanation of covered and non-covered benefits and it is your choice to receive these materials and services or to decline. An itemized bill is provided for your information and records. If Moderne Eye Optometry is not a participating provider for your specific insurance plan, your signature below is an agreement to pay for exam services and/or materials privately. *By signing this form I acknowledge I have read and agree to the policies stated above.* We are happy to provide the information necessary to help complete your insurance forms.

Signature: _____ Date: _____

Method of payment: Cash Check Credit Card (except AMEX)

I acknowledge that there has been no change to the above information:

Initial/Date

Initial/Date

Initial/date