Ideal EyeCare® OPHTHALMOLOGY

APPOINTMENT CHECKLIST-ADULT

- Current health insurance information, including ID card
- Photo identification
- Complete registration forms from link provided or download and print forms from our website.

  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 15 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

Ideal EyeCare OPHTHALMOLOGY

Name (Last, First, MI):		Date of Birth:	Age:
SSN:	Gender:	Marital Status:	
Cell Phone:	Email:		
Home Phone:			
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:		
How did you hear about us?			
□ Google/Internet Search □ YouTube ad □ Facebook/Instagram □ Word of Mouth □ Physician referral □ Other_______________			
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 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.**

IdealEyeCare 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: ______________

Ideal EyeCare OPHTHALMOLOGY

FINANCIAL POLICY

The following information is regarding your account at Ideal EyeCare. Please read these policies carefully and discuss any questions or concerns with our staff. We look forward to providing you and your family with excellent eye care.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. 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, coverages change frequently and we cannot be held liable for misquoted benefits or eligibility.
- 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 a valid referral is on file for all visits.
- 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. Strabismus patients are responsible for an additional fee of $40.00 for a prism refraction (total $95.00). 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.
- Telemedicine visits, whether scheduled or requested, will be billed to your insurance company and you may be responsible for out-of-pocket costs such as copays or deductibles.
- We do not participate with any vision plans and you are responsible for all “routine” and/or non-covered services provided to you or your child. This includes myopia management evaluations.
- All “self pay” patients are required to pay in full at the time services are rendered. We offer a 20% prompt-pay discount on all professional services and will 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 is due in full at the time of service.
- The parent bringing the child for treatment is 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.
- All returned checks are subject to a $35.00 processing fee and will result in refusal to accept future payments by check.
- 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 insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- There is a **$50.00** per page fee for summary of care letters or other requests requiring a drafted and signed letter from the doctor.
- You will be assessed a **$50.00 NO SHOW** fee for any appointment that is missed or cancelled within 24 hours of your scheduled appointment. You must pay this amount before you will be allowed to schedule another appointment. We offer reminder notifications be text/phone/email as a courtesy, but it is your responsibility to update your calendar. It is very important that you keep our office updated with your most current information.
- Per NRS 629.021, we charge $0.60 per page for copies of your medical record, whether provided via paper or electronic access. You may also be assessed applicable postage costs if you prefer to have the records sent via mail. These fees are waived if records are transferred directly to another physician for continued care.

I have read and understand the above information.

Patient Name:____ **Date:**______________

Signature of Patient/Legal Guardian:____ **Date:**______________