Notice of Privacy Practices

Methods of Payments

No Insurance?

No problem! Claremore Eye Associates offers a discount for all non-insurance patients for their vision exam. We also accept all major credit cards, as well as Care Credit, cash and checks.

Vision Plans

Some insurance plans do not provide an insurance card Vision plans (examples: VSP, EyeMEd, Comp8Benefits/Humana, etc.); usually include benefits towards either glasses or contact lenses a very select few plans may cover both or offer a second of glasses per year for patients less than 20 years of age, and they do NOT cover contact lenses.

Medical Insurance

Refractions (checking vision/glasses prescription) and the contact lens portion of the exam are not generally covered by medical plans. We can file your insurance on your behalf, but this does not guarantee payment and any balance will be paid by you. If your deductible has not yet been met for the year, you will be responsible for services rendered. We keep medical insurance information on file because we perform medical eye care. We use medical insurance for infections, foreign body removals, eye disease, treatments, etc.

We are glad to answer any questions regarding your insurance benefits. Thanks!

Authorization & Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the release of any information including the diagnosis and records of any treatment or examinations rendered to me or my child to: _______________________________________

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices (available at the front desk).

Patient Name: ____ **Date:** ______________________

Signature of Patient or Guardian: ________________________________

GENERAL INFORMATION

Today's Date: ______________ **Last Exam:** ____________
Name: ____

Last First Middle

Street: ____

City: ___________________ **State:** __________ **Zip:** _________

Home Phone: ______________ **Cell Phone:** _______________

Email Address: _____________________________________

Preferred Method of Communication: Home Cell Text Email

Preferred Language: English Spanish Other

Race (circle): White, American Indian/Alaska Native, Asian, African American, Hispanic, Native Hawaiian/other Pacific Islander
Ethnicity (circle): Hispanic/Latino, Native Hawaiian/ other Pacific Islander, Not Hispanic or Latino

Social Security Number: ______________________________

Employer (or School): ________________________________

Occupation (or Grade): _______________________________

Date of Birth: ___________________ **Sex:** _______________

Vision Insurance: ____________________________________

Medical Insurance: ___________________________________

Insured's Name: _____________________________________

Insured's Employer: __________________________________

Insured's SS#: ____________________ **Group #:** ____________

Thank you very much for choosing Claremore Eye Associates—Vision Source and Drs. Smith, Stover and Crissup for your vision and eye health care! We value your opinion and hope to provide you with the best care. Please let us know if there is any way we can improve your visit.

Welcome to Our Office

Do you…
Work at computer for long periods? Yes/No
Want information on thinner or more technologically advanced lenses? Yes/No
Have prescription sunglasses? Yes/No
Spend a lot of time outdoors? Yes/No
Have an interest in laser vision correction? Yes/No
Have you ever worn/currently wear soft contact lenses? Yes/No
What kind? ______________________________
Cleaning solution for contacts? ______________
Are you interested in contact lenses? Yes/No

EYE HISTORY

Have you had any of the following:

	Yes	No		Yes	No
Eye Injury	☐	☐	Itching	☐	☐
Eye Surgery	☐	☐	Nausea	☐	☐
Eye disease	☐	☐	Tearing	☐	☐
Lazy eye	☐	☐	Dryness	☐	☐
Cataracts	☐	☐	Eyestrain	☐	☐
Glaucoma	☐	☐	Soreness	☐	☐

Are you currently experiencing any of the following?

	Yes	No		Yes	No
Flashes of light	☐	☐	Burning	☐	☐
Headaches	☐	☐	Sensitivity to light	☐	☐
Redness	☐	☐	Gritty feeling in eye	☐	☐
Double vision	☐	☐	Objects floating	☐	☐
Blurry near	☐	☐	Poor night vision	☐	☐
Blurry distance	☐	☐	Glare	☐	☐

Name of primary physician, additional referring physician:____
Please list any sports or hobbies:____
Allergies to Medication & reaction:____

FAMILY MEDICAL HISTORY **Relationship**

Condition	No	Yes
Blindness	No	Yes__________________________
Cataracts	No	Yes__________________________
Glaucoma	No	Yes__________________________
Diabetes	No	Yes__________________________
Heart Disease	No	Yes__________________________
High Blood Pressure	No	Yes__________________________
Macular Degeneration	No	Yes____________________

SOCIAL HISTORY (please circle) Information will be kept confidential.

Never Smoked

Former Smoker, quit (circle) <1yr, 1-2yrs, 3-4yrs, 4-5yrs, 5+yrs, 10+yrs ago

Current Someday/Everyday smoker, ____ PPD, ____yrs

Current Smokeless Tobacco user

Alcohol use, amount__________, how often________

Recreational drug use___________________________

PATIENT MEDICAL HISTORY QUESTIONAIRE

Review of Systems

Please indicate if you are currently experiencing problems/symptoms in the following areas. Please list any prescription or over the counter medications you are taking for these problems.

Yes No Describe/List Medications

____ ____Constitutional____
(fever, weight loss/gain, fatigue)

____ ____ Ear/nose/throat/mouth/dental ____
(ulcers, infections, deafness)

____ ____ Cardiovascular ____
(high blood pressure, high cholesterol, palpitations, chest pain, congestive heart failure, bypass)

____ ____ Respiratory ____
(cough, shortness of breath, asthma)

____ ____ Gastrointestinal ____
(diarrhea, constipation, jaundice)

____ ____ Neurological ____
(vertigo, tingling, numbness, headaches)

____ ____ Musculoskeletal ____
(weakness, joint pain, back pain)

____ ____ Endocrine ____
(diabetic, thyroid)

____ ____ Hematological/Lymphatic ____
(anemia, freq infections, bleeding)

____ ____ Allergic/Immunology ____
(autoimmune, arthritis, immune deficiency)

____ ____ Genitourinary ____
(frequency, urgency, dysfunction)

____ ____ Psychiatric ____
(depression, anxiety, attention disorder)

____ ____ Skin/Breast ____
(rashes, lesions)

____ ____ Ocular ____
(glaucoma, infections, allergies, cataracts, macular degeneration)

Reviewed by _____________________________ Date ____________
Update reviewed by________________________ Date ____________
Update reviewed by________________________ Date ____________
Update reviewed by________________________ Date ____________
Update reviewed by________________________ Date ____________

Date: _____________________ **Last exam:** ________________________

Name: ____________________ ___________________ _____________
Last First Middle

Thank you very much for choosing Claremore Eye Associates—Vision Source and Drs. S. Smith, Stover and Crissup for your vision and eye health care. We value your opinion and hope to provide you with the best care. Please let us know if there is any way we can improve your visit.

Street: ____
City: __________________________ **State:** ___________**Zip:** ________________
Home Phone: ______________________ **Cell phone:** _______________________
Email Address: ____
Emergency Contact Name & Phone #: __________________________________

Race (circle): White, American Indian/Alaska Native, Asian, African American, Hispanic, Native Hawaiian/Other, Pacific Islander
Ethnicity (circle): Hispanic/Latino, Native Hawaiian/other, Pacific Islander, Not Hispanic or Latino

Social Security Number: ____
Employer (or School): ____
Occupation (or Grade): ____
Date of Birth: ___________________________ **Sex:** _________________
Vision insurance: ____
Medical insurance: ____
Insured's Name: ____
Insured's Employer: ____
Insured's SS#: _______________________________ **Group #:** __________

Welcome to Our Office
Do you
Work at a computer for long periods Yes/no
Want information on thinner or more Technologically advanced lenses? Yes/no
Have prescription sunglasses? Yes/no
Spend a lot of time outdoors? Yes/no
Have an interest in laser vision correction? Yes/no
Have you ever worn/currently wear soft contact Lenses? Yes/no
What kind? _____________________________
Cleaning solution for contact?________________
Are you interested in contact lenses? Yes/no

Eye History

Have you had any of the following

	Yes	no
Eye injury	___	___
Eye Surgery	___	___
Eye Disease	___	___
Lazy Eye	___	___
Cataracts	___	___
Glaucoma	___	___

Are you currently experiencing any of the following?

	Yes	No		Yes	No		Yes	No
Itching	___	___	Flashes of light	___	___	Burning	_____	___
Nausea	___	___	Headaches	___	___	Sensitivity to light	___	___
Tearing	___	___	Redness	___	___	Gritty feeling in eye	___	___
Dryness	___	___	Double Vision	___	___	Objects floating	___	___
Eyestrain	___	___	Blurry near	___	___	Poor Night vision	___	___
Soreness	___	___	Blurry distant	___	___	Glare	___	_____

Name of Primary Physician, additional referring physician____
Please List any sports or hobbies ____
Allergies to Medication & Reaction____

Family Medical History	**Relationship**
Blindness No Yes	_________________
Cataracts No Yes	_________________
Glaucoma No Yes	__________________
Diabetes No Yes	_________________
Heart Disease No Yes	_________________
High Blood Pressure No Yes	________________
Macular Degeneration No Yes	_______________

Social History (please circle) information will be kept confidential

Never Smoked Former Smoker- Quit (circle) <1yr-2yrs, 3-4yrs, 4-5 yrs 5+yrs, 10 + yrs ago
Current Someday/Every day smoker _____ PPD ____yrs
Current Smokeless Tobacco user
Alcohol use, amount _______ how often ________
Recreational drug use _________

PATIENT MEDICAL HISTORY QUESTIONAIRE

Review of Systems

Please indicate if you are currently experiencing problems in the following areas. Please list any prescription or over the counter medications you are taking for these problems.

Yes	No	Describe/List Medications
___	___	Constitutional____ (Fever, weight loss/gain, fatigue)
___	___	Ear/nose/throat/mouth/dental____ (Ulcers, infections, deafness)
___	___	Cardiovascular ____ (High blood pressure, high cholesterol, palpitations, chest pain, congestive heart failure, bypasses)
___	___	Respiratory ____ (Cough, shortness of breath, asthma)
___	___	Gastrointestinal____ (Diarrhea, constipation, jaundice)
___	____	Neurological ____ (Vertigo, tingling, numbness, headaches)
___	___	Musculoskeletal ____ (Weakness, joint pain, back pain)
___	___	Endocrine ____ (Diabetic, thyroid)
___	___	Hematological/Lymphatic____ (Anemia, freq infections, bleeding)
___	___	Allergic/immunology ____ (Autoimmune, arthritis, immune deficiency)
___	___	Genitourinary ____ (Frequency, urgency, dysfunction)
___	___	Psychiatric ____ (Depression, anxiety, attention disorder)
___	___	Skin/Breast ____ (Rashes, lesions)
___	___	Ocular ____ (Glaucoma, infections, allergies, cataracts, macular degeneration)

Reviewed by _________________ date _______________

Update reviewed by ___________ date________________