RAYMORE EYECARE

Bryan Huff, O.D 887 E Walnut St. Raymore, MO 64083
(816)318-EYES (3937) www.raymoreeyecare.com

GEE **CLXM** **MEDICAL** **RXCHECK** **CLCHECK**

Name:_____ Appointment Date:_____/_____/_____

Address:_____ Sex: M/F

City: _____Zip:_____ DOB _____/_____/_____ Age:_____

Email Address:_____ Social Security:_____/_____/_____

Phone: Home:_____ Work: _____ Cell: _____

Preferred Contact ____Any ____Phone ____Text ___Email

Employer:_____ Occupation:_____

Primary Physician:_____ Last Medical Exam:_____

Last Eye Doctor:_____ Last Eye Exam:_____

Preferred Language: ____English ____Spanish ____Other
Ethnicity: _____Hispanic or Latino
_____Not Hispanic or Latino

Race: ____American Indian or Alaska Native
____Asian
____Native Hawaiian/Other Pacific Isl.
____Black/African American
____White

Do you wear glasses? Y/N How old are your present lenses?_____
Do you wear contact lenses? Y/N How old are your present lenses?_____

INSURANCE

Vision: Eye Med VSP Superior Humana Vision NVA Union Other: _____

Medical: Aetna BCBS Coventry Cigna UHC Humana Medicare GEHA Other: _____

Medical Copay:_____ Deductible: _____

*Note: Please provide a medical insurance card for verification of any vision or medical coverage.
Many “routine” exams become medical exams based on the doctor’s finding during your exam.

Name: _____ DOB: _____ Today's Date: _____

Reason for Visit: _____

_____

_____

Do you currently have any of the following conditions? Check all that apply.

Cataract		Eye infections/Allergy	
Macular Degeneration		Flashes/Floaters	
Glaucoma		Iritis/Uveitis	
Diabetes		Retinal defects/Degeneration	
Diabetic Retinopathy		Other:	
Dry Eye			

Explain your eye concerns:

Blurred vision			Headaches		Redness		
	Near		Poor night vision		Burning		
	Far		Night glare		Itching		
	Both		Double Vision		Tearing		
			Total loss of vision		Discharge		
	Eyestrain		Other:				
	Eyepain						
	Lights sensitivity						

How would your grade your quality of vision with corrective lenses?

Distance:	Acceptable	May need work	Blurred
Near/Reading:	Acceptable	May need work	Blurred
Computer:	Acceptable	May need work	Blurred

Computer Demands:

How often are you on:				Outdoor demands?	
Computer		Multiple Monitors		Extended night driving	
Cell Phone		Simultaneously viewing		Outdoor in UV exposure	
Laptop		paperwork & computers		Read in outdoor setting	
Tablet/Ipad		Other:			
Other device					

Do you have any visual performance problems?		Contact Lens Interests?	
Poor reading skills/low reading performance		New Contact Lens Fitting	
Inconsistance sports vision		New Brand of Contacts	
Slowness when shifting focus		Daily-wear Contacts	
Difficulty viewing 3D, movies or TV		Different Replacement	
Eyewear Desires: Please circle all that apply		Overnight Wear	
Replace uncomfortable, lost/stolen or broken glasses		Vision Therapy	
Glasses for special activites		New Supply of Contacts	
interested in specific fashion or brand			
Would like thinner, lighter lenses			
Reduction of glare			
Sports eye glasses			
New eyeglasses/lenses			
Prescription sunglasses			
Non-prescription sunglasses			
Computer glasses			
Reading glasses			
Other desires:			

Continued on reverse side.

REVIEW OF SYSTEMS: Check all that apply: **If none apply, check here -[ ]**

Constitution:		Cardiovasc:		GU:		Allergy/Imm:	
Dev. Disabilities		Hypertension		Kidney Disease		Drug Allergy	
Cancer		Stroke/CVA		Prostate Cancer		Environment Allergy	
Other		Congestive Heart Failure		BPH		Lupus	
ENT:		Other		Pregnant		Sjogren's Syndrome	
Hearing Loss		Respiratory:		Nursing		Other	
Sinusitis		Cigarette Smoker		Other		Integ:	
Dry Mouth		Asthma		Musc/Skel:		Eczema	
Laryngitis		Bronchitis		Osteoarthritis		Rosacea	
Other		Emphysema		Arthritis		Psoriasis	
Neuro:		Sleep Apnea		Fibromyalgia		Cold Sores	
Multiple Sclerosis		Other		Muscular Distrophy		Shingles	
Epilepsy		GI:		Ankylosing Spondylitis		Other	
Cerebral Palsy		Crohn's		Osteoporosis		Hem/Lymph:	
Tumor		Colitis		Gout		Anemia	
Stroke/CVA		Ulcer		Other		Lg Volume Blood Loss	
Migraine		Acid Reflux		Endo:		Ulcer	
Other		Celiac Disease		Type 2 Diabetes		Hypercholesteremia	
Psych:		Other		Type 1 Diabetes		Other	
Depression				Thyroid Dysfunction			
Attention Deficit				Hormone Dysfunction			
Anxiety Disorder				Other			
Bipolar Disorder							
Other							

Medications: _____

Allergies/Reaction: _____

Social History:	Circle all that apply						
Alcohol		Never	Seldom	Monthly	Weekly	Daily	Other
Tobacco Type		None	Pipe	Cigars	Cigarettes	Smokeless	Other
Tobacco Type		Never	Seldom	Light	Heavy	Daily	Former
Family History:	Circle Relationship						
Cancer	N/A	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type 1	N/A	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type 2	N/A	Father	Mother	Brother	Sister	Son	Daughter
Hypertension	N/A	Father	Mother	Brother	Sister	Son	Daughter
Hyperthyroidism	N/A	Father	Mother	Brother	Sister	Son	Daughter
Hypothyroidism	N/A	Father	Mother	Brother	Sister	Son	Daughter
Other	N/A	Father	Mother	Brother	Sister	Son	Daughter
Family Ocular History:	Circle Relationship						
Cataract	N/A	Father	Mother	Brother	Sister	Son	Daughter
Disorder of Macula	N/A	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	N/A	Father	Mother	Brother	Sister	Son	Daughter
Other:_____	N/A	Father	Mother	Brother	Sister	Son	Daughter

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SERVICE AGREEMENT

Please be advised that you if you are using insurance coverage for today's visit, this is a contract between you and your insurance company…not Raymore Eyecare.

Insurance quotes are not a guaranteed benefit until the claim has been submitted and processed. If your insurance company has not reimbursed our office within 90 days, you will be responsible for the outstanding balance.

No Refunds are given for Professional Services.

Signature:_____

Date:_____

CONTACT LENS FITTING FEE

This fee covers the extra tests performed by the doctors along with any necessary follow-up visits, and trial lenses. These procedures are only done on patients that wear contacts; it is in addition to the services provided during the annual eye exam.

I acknowledge a contacts lens fitting is a separate procedure and fee and is not covered by my vision insurance unless otherwise noted:

Signature:_____

Date:_____

HIPPA

HIPAA (Health Insurance Portability and Accountability Act of 1996).

This office is also committed to protecting your personal information and adheres to all Federal Privacy Guidelines. The HIPAA policies are posted in the office and you may request to have your own copy.

Please sign below once you have read and understand the included "NOTICE OF PRIVACY PRACTICES", indicating you are aware that this office complies with all HIPPA Privacy Guidelines.

_____ _____

Signature (Parent/Guardian) Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.