Patient Legal Name: First______________________ M.I. __ Last______________________
Preferred Name:____
Address:____**APT#**____________

City:______________________________________**ST:**___________**Zip:**________________

Preferred Phone (C/H/W):________________ **DOB**:___________ **SSN**_________________

Patient Sex (Required by insurance) M F

Preferred Pronouns (Check One): He/Him/His, She/Her/Hers, They/Them/Their

Email:____

Employer: __________________________ **Occupation:**_______________________________

Emergency Contact:_____________________________ **Contact Phon**e:_________________

Parent/ Guardian with patient:____

Insurance Name:___________________________ **Insurance ID #:**______________________

Subscriber Name:________________________Subscriber Date of Birth:___________________

Pharmacy:______________________________ **Family Doctor:**__________________________

Referred By: ( )Patient______________ ( )Provider______________( )Other:___________

Race: ( )Caucasian ( )African American ( )Asian ( )Other_________________________

Ethnicity: ( )Non-Hispanic ( )Hispanic-Latino

Please Read: Payment for services is due at time services are rendered unless other arrangements have been made in advance. Most insurance policies pay only a portion of your total charges. **Ultimate responsibility for verifying insurance coverage and eligibility rests with the patient. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company** and that final determination can only be made when the claim is processed. Accounts 60 days old are subject to additional collection fees and interest charges of 1.5% per month.

There will be a service charge on all returned checks. I understand (even if I do have insurance) that I will be financially responsible for payment of all charges incurred for services from this office. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefit either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for the services rendered. **I understand that a cancellation fee of $80 may be applied to all appointments missed or changed with less than 24 hours' notice.**

- **Signature** ____ Date: ________________

Acknowledgement of Receipt of Privacy Policies: I acknowledge that I have received a copy of the Notice of
Privacy Practices for this office. ☐ Self ☐ Guardian

- **Signature** ____ Date: ________________

Agreement to receive messages: I agree to receive information via email, text, or voice.

- **Signature** ____ Date: _________________

RooseveltVision **NAME**: ______________________________ Date: ________________

Reason for Visit:____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

	Yes	No
Constitution		
Cancer	☐	☐
Ear/ Nose/ Throat		
Sinus Condition	☐	☐
Hearing Loss	☐	☐
Dry Mouth	☐	☐
Neurologic		
Cerebral Palsy	☐	☐
Migraines/Headaches	☐	☐
Epilepsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Multiple Sclerosis	☐	☐
Psychological		
ADD/ ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory		
Bronchitis	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Yes	No
Gastrointestinal (digestive)		
Colitis	☐	☐
Crohn's Disease	☐	☐
Celiac Disease	☐	☐
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Integumentary (skin)		
Rosacea	☐	☐
Shingles (zoster)	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Cold sores (simplex)	☐	☐
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Blood Disorders		
Anemia	☐	☐
High Cholesterol	☐	☐
Hepatitis A/B/C	☐	☐
Allergic/Immunologic Conditions		
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren's Syndrome	☐	☐
HIV/AIDS	☐	☐

Females : Are you currently pregnant or nursing? ***Yes*** ☐ ***No*** ☐

Other Medical Conditions or Surgeries:____

Height: _________________ Weight:_________________

Do you drink alcohol? YES ☐ NO ☐ Do you smoke? YES ☐ NO ☐ Former Smoker? YES ☐ NO ☐

Do you have (or have you previously had) any eye conditions? ☐ Cataract ☐ Glaucoma ☐ Macular Degeneration

Have you had any eye surgeries? NO ☐ YES ☐ ; ____

Do you have a family member with any of the following conditions? If yes, who?

☐ Cataract ____ ☐ Diabetes ________________________________

☐ Glaucoma ______________________________________ ☐ High Blood Pressure ______________________

☐ Macular Degeneration ____________________________ ☐ Cancer __________________________________

☐ Other ____

LIST CURRENT MEDICATIONS AND DOSAGES:____

____

____

LIST CURRENT EYEDROPS: ____

DRUG OR OTHER KNOWN ALLERGIES: ____

LATEX SENSITIVITY? YES ☐ NO ☐

POLICIES REGARDING CONTACT LENSES AND PROFESSIONAL FEES

Contact lenses are regulated medical devices. At Roosevelt Vision, we follow all state and federal regulations in order to provide the best opportunity for safe and successful contact lens wear and minimize the risk of potentially serious complications. Federal regulations require contact lenses to be evaluated on the eye, at least once every two years for a contact lens prescription to be issued. Contact lens related professional services are separate from and are not included in a general eye examination.

PROFESSIONAL FEES

All contact lens services include a detailed evaluation of the patient's prescription and ocular surface health, review of available contact lens technology, and instruction on proper care, maintenance, and replacement. Contact lens fees vary based on unique patient needs and the complexity of the fitting. The doctor or contact lens specialist will determine the exact fee level for each patient at the time of examination. Fee ranges are listed below:

Contact Lenses Evaluation– $65 to $100

- *Evaluation and updated prescription of a patient's current contact lenses.*

Contact Lens Fitting for Experienced Users – $125 to $250

- *Refitting into a different brand/material or category of contact lenses for patients who currently wear contact lenses. Fee includes one follow-up visit to verify that the new contact lenses are performing as expected and that the eyes are healthy.*

Contact Lens Fitting for New Users– $150 to $275

- *First time fitting for patients who have never worn contacts before. Includes instruction and training on how to safely handle, insert, remove, and care for contact lenses. Fee includes one follow-up visit to verify that the new contact lenses are performing as expected and that the eyes are healthy.*

Professional fees are non-refundable, and do NOT include the cost of the contact lenses. Same day services for fittings may be limited by availability of diagnostic lenses in office. All follow up evaluations must be completed within 60 days. If the need arises for further care, additional fees will be charged. Contact lens prescriptions will be issued after completing the required follow up visits. Please be aware that insurance companies rarely cover the entire cost of contact lens professional services, and that any non-covered fees are due at the time of service.

Patient Name ____ DOB ______________

On behalf of the patient named above, I understand the fitting process and: (select one)

- ❑ wish to proceed with contact lens services today.
- ❑ decline contact lens services today.

I acknowledge I have been informed a copy of my final prescription will be on my online Personal Health Record.

____ ______________

Signature of Patient (or Parent/Guardian if patient is under 18 years old) Date

10/15/2020