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| Lifestyle Questions |
| Do you use a computer on your job? . . . . Yes No # hours daily \_\_\_\_\_\_\_\_\_\_  Do you use a computer at home? . . . . . . Yes No # hours daily \_\_\_\_\_\_\_\_\_\_  In what recreational/sports activities do you participate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you wear any special or protective eye gear for your sport? Yes No  Does your vision, or do your lenses, interfere with your activity? Yes No  What are you doing to protect your eyes from ultraviolet exposure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you currently wear glasses that have an anti-reflective coating? Yes No  Do you experience any of the following discomforts at work or at home? (Check only those that apply)   Headaches? Letters blur as you read? Occasionally see double?   Eyestrain? Eyes red or watery?  Pulling sensation near eyes?   Get sleepy? Lose your place often?  Do you avoid certain tasks?  Does it take more and more effort to see clearly as the day wears on? Yes No  Do you avoid reading after work, but read on weekends? Yes No  How long can you read? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you “hunch” closer to your work as the day wears on? Yes No  Do street signs ever seem blurred as you drive home from work? Yes No  Do you find being dependent on reading glasses too bothersome? Yes No |

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| **Insurance Information** |
| Primary’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vision Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medical Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Professional services are rendered and charged to you, not your insurance company. Please understand that any insurance contract is between you and the insurance company and payment for services and materials are your responsibility. We many need to file claims with your medical insurance company for the diagnosis and treatment of medical conditions not covered by your routine vision benefits. We will accept assignment of claims for primary eye care and medical insurance. All deductibles and fee amounts not covered by insurance are due at the time of the treatment. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. **If at the end of 60 days, your insurance company has not paid, you will be held responsible for the entire balance.** Upon request, we will supply you a copy of the claim so that you can re-submit if necessary. In order to honor your insurance benefits, you must provide insurance information (i.e.: insurance cards, benefits book, etc.) And we must be able to verify the current benefits available.  Agreement and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to **Norcross Eye** **Cente**r all insurance benefits. Further, despite my insurance coverage, I understand that I am financially responsible for all charges incurred. I hereby authorize the doctor to release all information necessary to secure payment benefits, I authorize the use of this signature on all insurance submissions.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**If you are here for a Contact Lens Exam, Please be aware that there is a separate charge for the Evaluation.**