Hanson eyecare and optical
Exceptional eye wear you desire...
Personalized eyecare you deserve.
239-936-2121

Dr. Hanson & Associates, P. A.

Patient Information Forms

Name _____ Date ____/ _____/ _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Guardian (if applicable) _____ Occupation _____

Date of Birth ____/ ____/ _____ Last Eye Exam _____

Do you have vision insurance? ❑No ❑Yes If yes, insurance carrier _____

Do you have health insurance? ❑No ❑Yes If yes, insurance carrier _____

Do you have Medicare? ❑No ❑Yes Email: _____

MEDICAL HISTORY

Do you have any allergies to medications? ❑No ❑Yes If yes, please explain

_____

Please List All Medications that you are currently taking (please include oral contraceptives, over-the-counter medications, vitamins, and home remedies)_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had

_____

_____

List any of the following that you have had or now have – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury_____

Do you wear glasses? ❑No ❑Yes If yes, how old are your current glasses? _____

Do you wear contacts? ❑No ❑Yes If yes, how old are your lenses? _____

Type of contacts: ❑Rigid ❑Soft ❑Extended Wear ❑Other_____

Are you happy with your current contacts? ❑Yes ❑No If not, what is bothersome about them?

_____

Are you pregnant or nursing? ❑No ❑Yes ❑Does not apply to me

Please turn over the pages, as information is needed on both sides of the pages.

MEDICAL HISTORY

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor, if preferred.

❑Yes, I prefer to discuss my social history directly with the doctor.

Do you drive? ❑No ❑Yes If yes, do you have visual difficulty when driving? ❑No ❑Yes

If yes, Please describe: _____

Do you use tobacco products? ❑No ❑Yes If yes, type/amount/how long?_____

Do you drink alcohol? ❑No ❑Yes If yes, type/amount/how long?_____

Do you use illegal drugs? ❑No ❑Yes If yes, type/amount/how long?_____

Have you ever been exposed to or infected with: ❑Gonorrhea ❑Hepatitis ❑HIV ❑Syphilis ❑ Herpes

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Review of Systems

Do you currently, or have ever had any problems in the following areas?

Constitutional	No	Yes	Unsure	**Ear, Nose, Mouth, Throat**	No	Yes	Unsure
Fever, Weight Gain/Loss	❑	❑	❑	Allergies/Hay Fever	❑	❑	❑
Integumentary				Sinus Congestion	❑	❑	❑
Skin	❑	❑	❑	Runny Nose	❑	❑	❑
Neurological				Post Nasal Drip	❑	❑	❑
Headaches	❑	❑	❑	Chronic Cough	❑	❑	❑
Migraines	❑	❑	❑	Dry Throat/Mouth	❑	❑	❑
Eyes				**Respiratory**			
Loss of Vision	❑	❑	❑	Asthma	❑	❑	❑
Blurred Vision	❑	❑	❑	Chronic Bronchitis	❑	❑	❑
Distorted Vision/Holes	❑	❑	❑	Emphysema	❑	❑	❑
Loss of Side Vision	❑	❑	❑	**Vascular/Cardiovascular**			
Double Vision	❑	❑	❑	Diabetes	❑	❑	❑
Dryness	❑	❑	❑	Heart Pain	❑	❑	❑
Mucous Drainage	❑	❑	❑	High Blood Pressure	❑	❑	❑
Redness/Itching/Burning (circle)	❑	❑	❑	Vascular Disease	❑	❑	❑
Foreign Body Sensation	❑	❑	❑	**Gastrointestinal**			
Foreign Body Sensation	❑	❑	❑	Chronic Diarrhea	❑	❑	❑
Sandy/Gritty Feeling	❑	❑	❑	Chronic Constipation	❑	❑	❑

Eyes	No	Yes	Unsure
Tearing/Watery	❑	❑	❑
Glare/Sensitivity	❑	❑	❑
Eye Pain/Soreness	❑	❑	❑
Chronic Infection (eye/lid)	❑	❑	❑
Sties/Chalazion	❑	❑	❑
Flashes of Light/Floaters	❑	❑	❑
Tired Eyes	❑	❑	❑
Endocrine			
Thyroid/Other Glands	❑	❑	❑
Allergic/Immunologic	❑	❑	❑

Genitourinary	No	Yes	Unsure
Genitals/Kidney/Bladder	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Psychiatric	❑	❑	❑

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition	**No**	**Yes**	**Unsure**	**Relationship**
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____

If you answered yes to any of these above or have a condition that is not listed such as high blood pressure, kidney disease, lupus, thyroid disease, or any other please explain and list medications that are being taken for any of these:_____
_____

How did you hear about us? ❑Facebook ❑Google ❑Friends & Family ❑Other: _____

Note: Please do not wear perfumes or colognes to the appointment, or any strong fragrances. Thank you very much!!

Dr. Hanson & Associates, P. A.

Insurance and Financial Responsibility Policy Agreement

Please fill out and read this form. Please provide Receptionist with most current insurance card/cards (medical and vision), and photo identification when you have completed all forms, front and back.

Patient's Name _____ Patient's Social Security Number _____

Subscriber's Name (if different from patient) _____

Subscriber's Date of Birth _____ Subscriber's Social Security # _____

Primary Medical Insurance Plan_____ Member ID# _____

Primary Vision Insurance Plan _____ Member ID # _____

Please Note: *All payments are to be paid at the time of service, including all co-payments and deductibles. If your insurance company does not pay your claim within 60 days, you will be responsible for paying the balance. If your insurance company pays us more than what is owed, we will send you a check immediately. Accounts that are past due of 60 days or more will be referred to collections. Insurance is a contract between you and your insurance company. Keep in mind that we are not party to the agreement. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or "usual and customary fees", other than to supply the factual information necessary. Also, authorizations given by your insurance company does not guarantee payment on your claim. You will be responsible for any claims that are unpaid by your insurance carrier, whether it be vision or medical benefits.* X_____ Initials

Medicare Patients: *Medicare DOES NOT cover "routine eye examination" or refractions. You will be responsible for the $50 fee plus any deductible that is not covered by your secondary insurance. A 20% fee will be charged for those that do not have a secondary insurance. Medicare covers only 80% of the visit. Medicare does not cover any optical products. You must have a vision plan for optical products to be covered. Dr. Hanson is a participating provider and does accept assignment.* X_____ Initials

Assignment and Release of Medical Information: *I hereby authorize Dr. Randal Hanson to release any information that is required to process my insurance claim. I also authorize insurance benefits to be directly paid to Dr. Randal Hanson. I understand that I am financially responsible for services that are not covered by my insurance. I have received a copy of Dr. Randal Hanson's privacy policy regarding the care of confidentiality of my records and personal information. This authorization is in effect until I choose otherwise to revoke it. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original. Your signature will remain on file until otherwise revoked in writing.* X _____ Initials

Vision Insurance: If you have vision insurance, we will file your claim for your comprehensive examination, as well as eyeglasses and contact lenses. **If you have a medical diagnosis, such as diabetes or glaucoma, we cannot bill your vision insurance for your eye examination**. We will have to file a claim to your medical insurance and any additional services that are necessary. You cannot use your vision insurance combined with your medical insurance. I have discussed the additional fees and have agreed to proceed with the necessary diagnostic testing.

X_____ Initials

Patient's/Guardian Signature: _____ **Date:** _____

By signing this agreement, you understand the policies of the office of Dr. Randal Hanson and agree to all terms, including financial responsibility for all charges rendered.

Using Your Insurance

When you are using insurance, it is important and necessary for us to have both your medical and vision insurance information. This information is used only for your healthcare needs.

- If you have a medical condition that effects your vision, your eye examination will be billed to your medical insurance, as vision insurance will not cover this. Should you need to come in for an office call (example: eye redness, irritation, flashes of light, or pain the eye), we will need to file to your medical insurance. If you have no insurance, you will be financially responsible. You may ask for estimate of costs at the time of the exam, but this is only an estimate on what the doctor feels will be necessary for treatment/and or the necessary services needed for you.

Vision Insurance covers annual vision, eye health and wellness examinations, and refractions only. Sometimes, contact lens evaluations may be covered, but this is dependent upon your vision plan. Follow-up appointments are required when getting your initial contact lens fitting and the follow-ups are covered as part of the initial evaluation. In some cases additional testing may be necessary to rule out a possible pathology. These tests are not covered by your vision insurance. You will be informed of any cost that may be out of pocket before any testing is performed.

X _____ Date: _____

Patient Signature or Guardian (if patient is a minor)

Out of Network Medical Insurances:

If your primary medical insurance is out of network **(including but not limited to BCBS, Anthem BCBS, Humana Gold HMO, Medicare Aetna HMO (Coventry), Medicaid, Wellcare, and Staywell)** you will be finically responsible for all charges at the time of your visit.

X _____ Date: _____

Patient Signature or Guardian (if patient is a minor)

Medical Diagnostic Testing:

I give my permission to do any necessary diagnostic testing that Dr. Randal Hanson suggests, during my visit and I understand that some or all of the charges may not be covered by my insurance and may possibly be an out of pocket expense. I agree to pay any uncovered charges at the time of my visit.

X _____ Date: _____

Patient Signature or Guardian (if patient is a minor)

Notice of Privacy Practices

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice briefly describes how we protect your health information and what right you have regarding it. If you would like a more thorough version, please ask one of our staff members.

Treatment, Payment, and Health Care Operations

The most common reason why we use or disclose your health information is for treatment, payment, or operations. We routinely use your health information inside our office for these purposes without any special permissions.

Patient Records Release

If we need to disclose your health information outside of our office for any reason, we will ask you for a special written permission.

Appointment Reminders

We may call, text, email, and/or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also communicate via any of these options to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder of a post card, and/or leave you a reminder message on you voicemail.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

Acknowledgement of Receipt

I acknowledge that I received a copy of **Hanson Eye Care** 's Notice of Privacy Practices.

X _____	X _____	_____
Patient Name	Signature	Date