PATIENT INTAKE & HEALTH HISTORY

Patient Legal Name:	DOB:	Date:

Your minimum exam copayment today could be: Routine $_____ Medical $_____ Contact Fit $_____ (if applicable)

Final charges will be determined once your exam is completed.

Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____

PATIENT INFORMATION

Preferred Name	Gender	Age
Home Phone #	Home Address	
Cell Phone #		
Email Address	Employer	
SSN (if ins. requires)	Occupation	

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

VISION INSURANCE	MEDICAL INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	City & Zip Code

HIPAA PRIVACY NOTICE

The HIPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide information for one individual with whom we may share your medical records.

Authorized Individual _____ Phone Number _____

STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting, and should there be any follow-up appointments required after the three months have past, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ Date _____

Patient Name: DOB: Date:

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible.
Please check all of the conditions that apply to you:

Respiratory Issues	☐ Yes	☐ No	**Hematologic Conditions**	☐ Yes	☐ No	**Ear/Nose/Throat Problems**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	**Allergy/Immunology**	☐ Yes	☐ No	**Neurological Disorder**	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No	Multiple Headaches	☐ Yes	☐ No
Endocrine Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Gastrointestinal Issues	☐ Yes	☐ No	**Musculoskeletal Conditions**	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	**Kidney/Bladder Problems**	☐ Yes	☐ No
Cardiovascular Conditions	☐ Yes	☐ No	**Psychiatric Disorder**	☐ Yes	☐ No	**Sexually Transmitted Diseases**	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Depression	☐ Yes	☐ No	**Surgical Operations**	☐ Yes	☐ No

Have you previously had any eye injuries, eye surgeries or eye diseases? ☐ Yes ☐ No If yes, please describe:

Have you experienced any floaters, flashes of light, burning, itching, redness, dryness, double vision, unusual blurry vision, frequent styes/chalazions, or excessive tearing/watering? ☐ Yes ☐ No If yes, please describe:

Do you have light sensitivity or issues with glare while outdoors or driving? ☐ Yes ☐ No ☐ Sometimes
Do you have issues with glare or have eye fatigue while on a computer? ☐ Yes ☐ No ☐ Sometimes

Are you currently being treated for any other medical conditions? ☐ Yes ☐ No If yes, please describe:

Please list any medications you are currently taking *(Including hormones, vitamins, birth control, aspirin, other anti-inflammatory, eye drops, etc.)* : ☐ None

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Are you currently pregnant or nursing? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐ Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

CONTACT LENS INFORMATION

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, please list the brand: _____

How many hours a day do you wear contacts? _____ How often do you throw away your lenses? _____

Do your eyes feel dry while wearing contacts? ☐ Yes ☐ No What do you use to clean your lenses?_____

FAMILY HISTORY

Has anyone in your family had any of the following illnesses?

Blindness*	☐ Yes	☐ No	Relationship: _____
Cancer*	☐ Yes	☐ No	Relationship: _____
Cataract	☐ Yes	☐ No	Relationship: _____
Color Blindness*	☐ Yes	☐ No	Relationship: _____
Diabetes*	☐ Yes	☐ No	Relationship: _____
Glaucoma*	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
High Blood Pressure*	☐ Yes	☐ No	Relationship: _____
Lazy Eye*	☐ Yes	☐ No	Relationship: _____
Macular Degeneration*	☐ Yes	☐ No	Relationship: _____
Respiratory Disease	☐ Yes	☐ No	Relationship: _____
Retinal Detachment*	☐ Yes	☐ No	Relationship: _____

**Additional testing may be covered through your medical insurance.*

For Office Use Only

L	FDT	PHOTO
A	O	

Harpers Point Eye Associates

Elliot M. Kirstein, OD, FAAO
Todd A. Zelczak, OD, FAAO
Alex D. Gibberman, OD, FAAO
Tyler W. Dowdall, OD

Important Insurance Information for Our Patients

Understanding your insurance coverage can be quite a challenging task. Our goal is to assist in maximizing your insurance benefits for your eye care. Individuals in our office may have coverage for routine vision care, medical, as well as materials such as glasses or contact lenses. Your insurance(s) may be billed for routine and/or medical services dependent on diagnosis, testing performed or prior medical conditions. We encourage you to become familiar with your policy exclusions, deductibles, and co-payments as outlined by your vision or medical provider when you elected your plan.

Vision vs. Medical Plans

If my eye doctor determines I am at risk of an eye disorder or eye disease before or during examination:

- Additional testing and evaluation may be necessary to manage vision and eye health. Examples can include patients with diabetes, macular degeneration or glaucoma.
- Special testing will be billed to medical health insurance outside and not to routine vision coverage.
- Co-payments, deductibles, and co-insurance, and non-covered services are the patient's responsibility.

I understand:

- It is my responsibility to inform **Harper's Point Eye Associates** of any vision and/or medical coverage prior to examination.
- **Harper's Point Eye Associates** will submit both vision and medical claims when appropriate in order to maximize my benefits.
- For initial exam and any prescribed follow-up visits, my vision plan or medical insurer, not **Harper's Point Eye Associates**, determines the co-pay or co-insurance amounts due and is payable at time of service for each visit.
- Vision plans or medical insurance policies may restrict payment for some services, use restricted fee schedules (Usual and Customary Rates) and exclude coverage based on the premium paid for insurance and not our fees or recommended treatment.
- Vision plans and medical insurance policies belong to you and we have no leverage to obtain payment from your insurance carriers. We can only submit the claims. If you have questions regarding non-payments of claims, contact your insurance carrier for an explanation of benefits.

I acknowledge and understand the information above and authorize Harper's Point Eye Associates to file claims with my vision plans/medical insurance. I authorize benefits to be paid directly to Harper's Point Eye Associates and understand that I am responsible for any unpaid balance.

_____ **Date:** ____/____/____

Signature of Patient/Guardian of Insured

Harper's Point Eye Associates

Name: _____

DOB: _____

Date: _____

Elliot M. Kirstein, OD, FAAO
Todd A. Zelczak, OD, FAAO
Tanya Rana, OD, FAAO
Esther E. Lautz, OD

Wellness Retinal Imaging

During your comprehensive eye examination, our eye doctors will determine your eyeglass prescription as well as evaluate your eye health. Many important eye and medical health conditions can be detected during your examination such as diabetic retinopathy, macular degeneration, glaucoma, cataracts, retinal detachments, ocular tumors and many more. Most of these diseases are a-symptomatic, vision threatening and can occur at any age.

Informed Consent

As part of your eye exam, our office also recommends a special diagnostic test called **Wellness Retinal Imaging**. This new technology consists of capturing an image of the inside of the eye (the retina) using a medical digital camera. This is not an X-ray or ultrasound procedure. Nothing will touch your eyes. This permanent record is valuable in assessing the current health of your eye and serves as a basis for future comparisons. Insurance does not cover this Wellness procedure.

The fee for Wellness Retinal Imaging is $40

Please check one:

_____ YES, I DO want the Wellness Retinal Imaging

_____ NO, I DO NOT want the Wellness Retinal Imaging

Main Office
8211 Cornell Rd, Suite 510
Cincinnati, Ohio 45249
513-530-0440

Norwood Office
4600 Smith Rd
Cincinnati, Oh 45212
513-631-8889

Forest Park Office
1124 Kemper Meadow Dr.
Cincinnati, Oh 45240
513-851-2414

www.harperspointeye.com

Take the dry eye questionnaire & Share the results with your eye doctor

To help determine if you may have Chronic Dry Eye disease, take the **Dry Eye Questionnaire** eye doctors use.

Answer the following questions based on the last week and follow the steps to get your score.
Share the results of where you fall on the Dry Eye Severity Scale with your eye doctor.

A Have you experienced any of the following?

Physical Symptoms	All of the time		Half of the time		None of the time
Eyes that are sensitive to light	4	3	2	1	0
Eyes that feel gritty	4	3	2	1	0
Painful or sore eyes	4	3	2	1	0
Blurred vision	4	3	2	1	0
Poor vision	4	3	2	1	0

A Total ☐

B Have problems with your eyes limited you in performing any of the following?

Daily Symptoms	All of the time		Half of the time		None of the time
Reading	4	3	2	1	0
Driving at night	4	3	2	1	0
Working with a computer	4	3	2	1	0
Watching TV	4	3	2	1	0

B Total ☐

C Have your eyes felt uncomfortable in any of the following situations?

Environmental Factors	All of the time		Half of the time		None of the time
Windy conditions	4	3	2	1	0
Places with low humidity (very dry)	4	3	2	1	0
Areas that are air conditioned	4	3	2	1	0

C Total ☐

D Add A, B & C to find D

☐

Locate "D" on the horizontal axis of the Dry Eye Severity Scale

E Total questions answered

☐

N/A does not count as an answered question

Locate "E" on the vertical axis of the Dry Eye Severity Scale

F Dry Eye Score

☐

Where D & E meet is where your score falls on the Dry Eye Severity Scale

Dry Eye Severity Scale

Number of all questions answered	normal		mild	moderate					severe	
12	10.4	20.8	31.3	41.7	52.1	62.5	72.9	83.3	93.8	100
11	11.4	22.7	34.1	45.5	56.8	68.2	79.5	90.9	100	
10	12.5	25	37.5	50	62.5	75	87.5	100		
9	13.9	27.8	41.7	55.6	69.4	83.3	97.2			
8	15.6	31.3	46.9	62.5	78.1	93.8	100			
7	17.9	35.7	53.6	71.4	89.3	100				
6	20.8	41.7	62.5	83.3	100					
5	25	50	75	100						
	5	10	15	20	25	30	35	40	45	48

Sum of scores for all questions answered

Allergan

COVID-19 QUESTIONNAIRE

These questions are intended to help preserve your health and safety as well as the health of fellow patients, our doctors and staff. We appreciate your understanding.

YES NO

☐ ☐ 1. In the past 14 days, have you experienced the following symptoms associated with COVID-19 as identified by the CDC?

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

☐ ☐ 2. Have you recently been in close contact* with anyone who has tested positive for COVID-19?

☐ ☐ 3. Have you recently been in close contact with anyone who has exhibited symptoms of COVID-19?

_____ _____

Patient Name (Print) Patient Signature

☐ ****By checking this box, I agree to today's evaluation.**

_____

Date

Note: Prior to examination, a temperature measurement may be taken.

***Close Contact is defined as being:** within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from (i) 2 days before illness onset; or (ii) for asymptomatic patients, 2 days prior to test specimen collection, both until the infected person was in isolation.

****From the American Optometric Association:** Doctors of optometry are frontline physician providers of essential care. … Based on the immediate health needs of a patient, doctors of optometry can and should use their professional judgment to determine the timing and course of care.

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