Medical History Questionnaire   Rebuck Associates Eye Care

Patient Name: ____ Today's Date: ______________________
Address: ____ Home Phone: ______________________
City: ______________________ State: _________ Zip: ___________ Cell Phone: ________________________
Email: ____ Work Phone: _______________________
Birth Date: ___________________ Social Security #: _______________ Preferred Contact: H ___ C ___ W ___
Guardian (If Applicable): ___________________________________ Occupation: ________________________
Name of Medical Doctor: ___________________________________ Dr.'s Phone: ________________________
Last Medical Exam: ____ Last Eye Exam: _____________________
With whom may we discuss your medical history (spouse, parent, sibling, etc)? ______________________________
How did you hear about us? ____

Medical History

Do you have any allergies (medications, food, latex, etc)? ☐ no ☐ yes If yes, please list: __________________________
____

List all medications you take (including oral contraceptives, aspirin, over the counter and home remedies):
____
____

List all major injuries, surgeries, hospitalizations: ____
____

Have you had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, LASIK, cataracts, eye infections, or eye injury: ____

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present prescription? ____________

Do you wear contacts? ☐ no ☐ yes If yes, how old is your present pair of lenses? ___________

Type of contacts: ☐ Hard ☐ Soft ☐ Extended Wear ☐Other Are they comfortable? ☐ yes ☐ no
Brand, if known: __________________________ Do you sleep in your contacts? ☐ yes ☐ no

Family Medical History

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

Disease/Condition	NO	YES	?	Relationship to you
Blindness	☐	☐	☐	____________________
Cataract	☐	☐	☐	____________________
Crossed Eyes	☐	☐	☐	____________________
Glaucoma	☐	☐	☐	____________________
Macular Degeneration	☐	☐	☐	____________________
Retinal Detachment/Disease	☐	☐	☐	____________________
Arthritis	☐	☐	☐	____________________
Cancer	☐	☐	☐	____________________
Diabetes	☐	☐	☐	____________________
Heart Disease	☐	☐	☐	____________________
High Blood Pressure	☐	☐	☐	____________________
Kidney Disease	☐	☐	☐	____________________
Lupus	☐	☐	☐	____________________
Thyroid Disease	☐	☐	☐	____________________
Other____________________	☐	☐	☐	____________________

* PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU *

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

□ Yes, I would prefer to discuss my social history information directly with my doctor. (Check box)

Do you have any visual difficulty while 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

Review of Systems

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

SYSTEM	NO	YES	?		NO	YES	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, weight gain/loss	□	□	□	Allergies/hay fever	□	□	□
Skin	□	□	□	Sinus congestion	□	□	□
Neurological				Runny nose	□	□	□
Headaches	□	□	□	Post-nasal drip	□	□	□
Migraines	□	□	□	Chronic cough	□	□	□
Seizures	□	□	□	Dry throat/mouth	□	□	□
Eyes				**Respiratory**			
Loss of vision	□	□	□	Asthma	□	□	□
Blurred vision	□	□	□	Chronic bronchitis	□	□	□
Distorted vision/halos	□	□	□	Emphysema	□	□	□
Loss of side vision	□	□	□	**Vascular, Cardiovascular**			
Double vision	□	□	□	Diabetes	□	□	□
Dryness	□	□	□	Heart pain	□	□	□
Mucous discharge	□	□	□	High blood pressure	□	□	□
Redness	□	□	□	Vascular disease	□	□	□
Sandy or gritty feeling	□	□	□	**Gastrointestinal**			
Itching	□	□	□	Diarrhea	□	□	□
Burning	□	□	□	Constipation	□	□	□
Foreign body sensation	□	□	□	**Genitourinary**			
Excess tearing, watering	□	□	□	Genitals/kidney/bladder	□	□	□
Glare/ light sensitivity	□	□	□	**Bones, Joints, Muscles**			
Eye pain or soreness	□	□	□	Rheumatoid arthritis	□	□	□
Infection of eye or lid	□	□	□	Muscle pain	□	□	□
Sties or chalazion	□	□	□	Joint pain	□	□	□
Flashes/floaters	□	□	□	**Lymphatic, Hematologic**			
Tired eyes	□	□	□	Anemia	□	□	□
Endocrine				Bleeding problems	□	□	□
Thyroid/other glands	□	□	□	**Allergic, Immunologic**	□	□	□
				Psychiatric	□	□	□

If you have answered YES to any of the above or have a condition not listed, please give details:

____

____

____

Rebuck & Associates Eye Care Office Policies

By being examined at our office, you agree to the following policies:

1) If you want your examination to be billed to any type of coverage, then you must present your medical insurance and vision plan cards before we will treat you. If you do not, then we won't bill your insurance and you will have to pay in full on the date of service. We will not bill you later. If you are unable to pay on the date of service, then you must reschedule, unless it is a true ocular emergency. We do offer financing through Care Credit.
2) Vision plans (Davis, Spectera, VSP, Eyemed, etc.) only cover healthy eye exams for nearsightedness, farsightedness, astigmatism, and the need for reading glasses. If you have other eye conditions like cataracts, glaucoma, diabetes, red/pink eye, etc., then your vision plan will not be billed and it must be paid out of pocket or billed through your medical insurance. Your vision insurance will not be billed if your medical insurance denies your claim, except for the refraction/glasses testing charge.
3) Glasses testing/refraction (if your examination is medical in nature) and contact lens evaluations are separate procedures, so both have additional and separate fees, which are not covered by some vision plans or medical insurance. If you desire to get a prescription for contact lenses, then you must have a contact lens evaluation. You have the right to decline the refraction or contact lens evaluation, but you will be unable to order glasses or contact lenses without a current prescription. You can't legally order contact lenses from a glasses prescription, or vise versa
4) Co-pays must be paid on the date of your examination. If you can't pay your co-pay today, then you will have to reschedule. If we can verify that your medical coverage has an unmet deductible, then you will have to pay towards your deductible today and we will submit a claim to your insurance. After receiving the response from your insurance, we will notify you whether you owe any additional fees or are due a refund.
5) All charges incurred are the financial responsibility of the patient, parent, or guardian regardless if the insurance covers any of the fees. Our staff may attempt to explain your benefits, but we are not insurance experts. You are responsible for knowing what your benefits cover, whether you need a referral and for obtaining a referral prior to your examination.
6) Any balances remaining unpaid after 30 days will accrue 1.5% interest per month. Balances over 60 days may be taken to collections or court. You are responsible for all court costs. If you still don't pay, then this can be reported to credit agencies and this may constitute breach of contract, thus enabling cancellation of your insurance coverage.
7) There may be a charge when requesting copies of your medical records and all balances must be paid before this information will be released.
8) You have a right to your eyeglass prescription and as a patient you will be provided with a copy. Local opticians generally do a good job of filling our prescriptions, but we have some concern with the use of eyeglass vendors over the internet. Fitting eyeglasses properly involves precise measurements such as PD/pupillary distance and segment height that an internet vendor cannot provide. We provide these measurements at no charge for patients purchasing eyewear from us. If you want these measurements to buy your glasses elsewhere, there will be a $40.00 charge. Payment of this fee entitles you to free adjustments and prescription verification for the glasses.

Assignment and release

I request that payment of authorized benefits be made on my behalf to Rebuck & Associates Eye Care, PLLC for any services provided. My signature verifies request that payment be made to the doctor and also authorizes release of medical information needed to pay the claim. Co-pays, co-insurances and any deductibles are based upon the charge determination of the insurance carrier. I authorize use of my signature for all insurance claims and understand that this assignment remains in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

I understand that I am financially responsible for all charges whether or not paid by my vision or medical coverage and have been provided the privacy policy of this office.

Print name__________________________ Signature________________________

Date _______________

If the patient is covered under another person's policy then you must provide their name, date of birth and social security number.

Insured's name________________________ Date of Birth ____________________

Social security number _____-___-______ Relationship to patient ___________

Rev 10/2014

Dr. Richard C. Rebuck OD
R&A Eye Care, PLLC

805 N. Mildred Street
Suite #3
Ranson, WV 25438

Phone: (304) 725-2020
Fax: (304) 725-2027
www.RandAEye.com

Like us on Facebook!

We now offer two additional and optional services to provide even more comprehensive eye examinations. We typically recommend that all of our patients have both tests done, especially if this is your first visit to our office. These tests often reveal conditions that could be otherwise missed during a routine exam. When you choose to have both tests you save $10.00.

Our first option test is the Optomap Retinal Scan allows us to take a digital picture through the undilated pupil (of most patients) to provide a much wider view of the retina and optic nerve to evaluate the health of your eyes. It allows us to detect many diseases earlier. Each picture will be kept in your file for future comparisons during annual eye exams. The Optomap is the next best thing to dilation but it is not a substitution, although it does enable us to detect issues that can be missed even with dilation.

The charge for the Optomap Retinal Scan is **$30.00**. Please check which option you prefer.

___ Yes, I choose to have this additional testing.

___ No, I understand that some conditions are less likely to be detected without this test, I would like to discuss it with Dr. Rebuck.

Our Second optional test is the OCT. This takes a three dimensional image (similar to a CAT scan) of the center of your retina and optic nerve.

The charge for the OCT is **$30.00**. Please check which option you prefer.

___ Yes, I choose to have this additional testing.

___ No, I understand that some conditions are less likely to be detected without this test, I would like to discuss it with Dr. Rebuck.

These are additional screenings that are NOT COVERED BY ANY VISION OR MEDICAL PLAN.

If you are having this done, please arrive 30 minutes before your appointment time.

___ Yes, I choose to have both tests and understand that I will pay an additional $50.00 today.

Signature ____
Date_____________
Parent or guardian, please sign if patient is less than 18 years old.

Glasses and Prescription Policy for Rebuck & Associates Eye Care

Thank you for considering purchasing your eyewear from us. We truly appreciate your business and we do our best to make sure that your glasses will fulfill your needs. The following are our policies on eyewear:

1. If your vision plan makes your glasses for our office, then you are subject to the vision plan's policies on cancellations, prescription changes, remakes, refunds, etc. and you will typically not be able to get glasses made elsewhere under your vision plan until you are again eligible for that benefit in 1 or 2 years.

2. You have a right to your eyeglass prescription and as a patient you will be provided with a copy. Local opticians generally do a good job of filling our prescriptions, but we have some concern with the use of eyeglass vendors over the internet. Fitting eyeglasses properly involves precise measurements such as PD/pupillary distance and segment height that an internet vendor cannot provide. We provide these measurements at no charge for patients purchasing eyewear from us. If you want these measurements to buy your glasses elsewhere, there will be a $40.00 charge. Payment of this fee entitles you to free adjustments and prescription verification for the glasses.

3. Please realize that it may take time to adapt to your new prescription, so you must try to wear your new glasses as much as possible for at least two weeks. If the vision seems strange when you pick them up, then take them home and put them on when you awaken tomorrow. If our practice makes your glasses, then we will remake the lenses once within 60 days of when you received them if you can't adapt to the prescription.

4. All prescription glasses are custom made. Once the lenses are started at our lab, we will not cancel your order or refund your money. Occasionally some patients have chosen a frame, but later decide that they don't like the frame after they receive their glasses. If we can cancel the order for the lenses before they're started, then we will refund 90% of the total frame and lens purchase (We charge a 10% restocking fee). If you want to cancel the order after the lenses are started, then we do not provide refunds. Please make sure that you are satisfied with your choice when your order is placed. We do not provide refunds for buyer's remorse (deciding after you selected your glasses that you no longer want to purchase them).

5. If you decide that you don't like the frame that you chose and the lenses have been started at our lab, we offer you the one time option of having your lenses put into another color of the same size and brand of frame when available. The lenses can't otherwise be used. We will offer you a credit of 60% of the cost of your lenses if you wish to switch to another style of frame after the glasses are made by our lab. If the frame is in brand new condition, then we will provide a full credit toward the cost of another frame from us. The frame you are returning must be the same frame that you purchased from us and be in brand new condition or no credit will be given.

6. Our staff does their best to calculate exactly how much you will owe for your glasses under your vision plan, but occasionally they will not be able to determine that exact amount until the claim has been processed by the vision plan or insurance. Please realize that you are responsible for any amounts indicated by your vision plan and you are financially liable for the entire cost of your glasses if your insurance declines payment for any reason.

7. We will notify you at least twice when your glasses are ready for pickup. The full balance must be paid before you may take them home. If you do not pick them up within 45 days of the first notification, then the lenses will be removed and the frame will be resold and there is no refund. If your vision plan notifies us that you still owe a balance on the glasses even though you already have received the glasses, then you will be notified of this bill and you agree to pay the balance within 30 days of notification.

8. It takes significant time and expertise for our staff to make lens and frame recommendations to our customers, so if you need or choose to change to a less expensive lens for any reason, we will remake your lenses once within 30 days, but you will not be refunded the difference in price and you must pay any frame cost above the 90% credited from the initial price of the frame, if you wish to change to another frame.

These policies have been provided to me and I agree to abide by them.

Name ________________________________ Signature ________________________________ Date _____________