

To Our Valued Patient:

Thank you for choosing Heartland Eye Consultants! We are looking forward to seeing you for your appointment. Enclosed you will find a location map and a couple of forms. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. You may mail or fax them back to us or bring them with you to your appointment, if there is not sufficient time for mailing.

Your appointment is on \_\_\_\_\_ at \_\_\_\_\_AM PM.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms
2. The History form
3. Your insurance card
4. Your co-pay
5. A list of any medications you take with the dosages
6. Your glasses

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be using your major medical insurance, not your 'eye' or 'eye glasses' insurance.

If your insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500 or 888-837-3937. Thank you for entrusting your vision to us!

Sincerely,

Patient Services

**Heartland Eye Consultants  
Adult Patient Demographics**

**Patient:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

When we contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circles.)

Call  Text Cell Phone: (\_\_\_\_) \_\_\_\_\_  Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_  Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Is this visit a result of an accident or illness *that occurred at work*? Yes No

Which doctor referred you to our office? \_\_\_\_\_ If not, please list \_\_\_\_\_

Who performed your last eye exam? \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Pediatrician/Family Physician: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

(Not living in household)

(Area Code)

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**If the patient is married, please complete spouse information:**

Spouse's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation \_\_\_\_\_ Title: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card.

For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment:

Cash                      Check                      Credit Card (Mastercard/Visa)

**Photo Release:**

I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

**AUTHORIZATION TO RELEASE INFORMATION TO YOU INSURANCE COMPANY AND ACKNOWLEDGEMENT OF  
PERSONAL RESPONSIBILITY FOR PAYMENT**

**I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.**

**A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for \$15.00. There is a \$25.00 fee for returned checks.**

**Authorized Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_**

ADULT PATIENT HISTORY

DATE OF COMPLETION: \_\_\_\_\_

Please be sure to fill in every blank. This will help your doctor better understand your problems. Thank you.

Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

What is the MAIN REASON you are seeking care today? (Be as specific as you can)

\_\_\_\_\_  
\_\_\_\_\_

At what age did you *first* wear glasses? \_\_\_\_\_

Date of your *last* eye examination? \_\_\_\_\_ Dr. \_\_\_\_\_

When was your last Physical exam? \_\_\_\_\_ Dr. \_\_\_\_\_

Using the following system, please tell your doctor if you have any of the following symptoms: Use "N" for never, "O" for occasionally, "S" for sometimes, and "F" for frequently. Please fill in every blank.

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Flashes of light                   | <input type="checkbox"/> Floaters/spots                        | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Burning                            | <input type="checkbox"/> Redness                               | <input type="checkbox"/> Tearing   |
| <input type="checkbox"/> Eye strain                         | <input type="checkbox"/> Light sensitivity                     | <input type="checkbox"/> Itching   |
| <input type="checkbox"/> Eye pain                           | <input type="checkbox"/> Blur at near                          |                                    |
| <input type="checkbox"/> Double vision (1 object seen as 2) | <input type="checkbox"/> Blur at distance (only after reading) |                                    |
| <input type="checkbox"/> Double vision (ghost image)        | <input type="checkbox"/> Blur at distance (all of the time)    |                                    |

Have you ever had an injury to your head, face or eyes? (circle) Yes No If yes, when? \_\_\_\_\_

Have you ever had a concussion: (circle) Yes No If yes, when? \_\_\_\_\_

Have you been in an car accident? (circle) Yes No If yes, when? \_\_\_\_\_ Have you been diagnosed with a closed head injury by a neurologist? (circle) Yes No If yes, who was the neurologist? \_\_\_\_\_

Do you have frequent headaches? (circle) Yes No

(If No, skip the following section.)

How frequent are your headaches? (circle) Monthly 1-2/Month Weekly 2-3/Week Daily

Where does it hurt? (circle as many that apply) temples forehead top of head back of head neck

Is the pain (circle) Dull or Sharp? Is the pain (circle) Constant or Throbbing?

How long does the headache usually last? \_\_\_\_\_ hours \_\_\_\_\_ days \_\_\_\_\_ other

How long have you suffered from these headaches? \_\_\_\_\_

Do your headaches usually occur at the same time of day? (circle) Yes No

If yes, please circle when: Mornings Afternoons Evenings

Please continue on next page.....

Do you have a crossed eye or a floating eye? (circle) Yes No

**If No, skip this section.**

Which way does it turn? (circle) Out In Up Down

Which eye turns? (circle) Right Left Alternates from right to left

Is the eye *always* turned? \_\_\_\_\_ If not, when does it usually turn? \_\_\_\_\_

\_\_\_\_\_ Is fatigue a factor? \_\_\_\_\_

Is the eyeturn apparent to others? (circle) Yes No

Is it getting (circle) Better Worse?

Was there any related trauma, fever, disease or condition that accompanied the onset of the eyeturn? \_\_\_\_\_

Do you have any other family members with an eyeturn? (circle) Yes No

List \_\_\_\_\_

Do you have any family members with lazy eye (reduced vision)? (circle) Yes No

If so, who? \_\_\_\_\_

Have you ever undergone patching therapy? (circle) Yes No If so, how old were you \_\_\_\_\_, how many hours per day did you patch \_\_\_\_\_ how many weeks/months did you patch \_\_\_\_\_

Do you have immediate family with any of the following:

Please put a Yes or a No in \_\_\_\_\_ Who? (sibling, parent, grandparent, etc.)  
every blank:

Glaucoma \_\_\_\_\_ \_\_\_\_\_

Cataracts \_\_\_\_\_ \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ \_\_\_\_\_

Diabetes \_\_\_\_\_ \_\_\_\_\_

Thyroid Disease \_\_\_\_\_ \_\_\_\_\_

Heart Disease \_\_\_\_\_ \_\_\_\_\_

Are you presently taking any prescription medications? (circle) Yes No

List medication and amount taken. Include asthma or allergy medication, birth control, etc

Have you been diagnosed with any allergies? (circle) Yes No

List \_\_\_\_\_

Do you have special visual needs? (Example: needlework, computer, golf, electrical or mechanical work, etc.)

Do you have a work environment, hobby, or sport that causes you different problems than your MAIN complaint? \_\_\_\_\_

Do you wish to add anything not covered? \_\_\_\_\_

Please return this form to the receptionist when you are finished. Thank you!

**CANCELLATION POLICY**

**Patient Name:** \_\_\_\_\_

**If patient is a minor, Parent Name:** \_\_\_\_\_

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that if you need to cancel your appointment with us that you call at least **24 hours prior to your appointment**. With your prompt cancellation, we will be able to schedule another patient in need of an appointment.

If you cancel, reschedule, or miss your scheduled appointment **without** 24 hours notice, the first time will be excused. However, if you miss a second appointment you will be responsible to pay a **\$50.00** fee. If a third appointment is missed, a **\$100.00** fee will be charged. This fee is **not** covered by insurance carriers, Medicare or Medicaid and will be your responsibility to pay before rescheduling.

I understand the above Cancellation Policy implemented by Heartland Eye Consultants.

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HEC Employee Witness

\_\_\_\_\_  
Date