

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)

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 _____

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: _____



9900 Nicholas Street ◦ Suite 250 ◦ Omaha, NE 68114
402-493-6500 ◦ 888-837-3937 (EYES) ◦ Fax: 402-493-4370

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

ADULT VISION HISTORY QUESTIONNAIRE

Please fill out this questionnaire carefully. Please mail or fax this form to us or bring it with you to your appointment. Thank you!

First Appointment: _____
Day Date Time

GENERAL INFORMATION

FULL NAME _____ DOB ____/____/____ AGE _____ Male Female

What is your occupation? _____

VISUAL HISTORY

Have you had a previous vision examination? Yes No If yes,
Doctor's Name _____ Date of last visit: _____
Reason for exam: _____ Results and recommendations:

Were glasses, contact lenses or optical devices recommended? Yes No
Was vision therapy recommended? Yes No Have you ever had vision therapy? Yes No

PRESENT SITUATION

Why do you feel the need for a visual evaluation? _____

How long has this problem/difficulty existed? _____

Do you experience any of the following?

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes feel tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea associate with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilt head during desk work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural changes when doing desk work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very bright light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very dim light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of interest or short attention span for close work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sustaining reading / writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
General or visual fatigue at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of Completion _____

	Yes	No	If yes, when?
Loss of place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skip lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetition of letter or words when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Omission of words when reading / copying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of finger to keep place	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Falling asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silent vocalization/moving lips while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Letters or words appear to move or float around when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty aligning columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Write or print poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inconsistent performance in work or sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor general coordination / clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with short-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with long-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comments on any items above:	_____		

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes No

If so, indicate the types of computer work you perform:

- Word processing
- Data entry
- Games / Leisure activities
- Other (explain): _____
- Programming
- Internet

How many hours do you spend in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

- Above your straight-ahead eye level
- At eye level
- Below eye level

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

- Directly in front of you when seated
- To your right
- To your left

Where are your source documents located?

- Directly in front of you when seated
- Flat (horizontal) or vertical
- To your right
- To your left

Do you experience any of the following lighting problems in your work area?

- Glare from windows or other light sources
- Reflections on your computer screen
- Difficulty reading source documents

Do you wear glasses, contact lenses or other optical devices for computer work?

Glasses Contact lenses Other (explain):

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____

Do you watch TV? Yes No

If yes, how many hours per day? _____ How many days per week? _____

Are you seriously involved with athletics? Yes No

Do you believe you are achieving up to your potential in sports/athletics? Yes No

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____

For what problem / condition? _____

Results and recommendations: _____

Medications currently using including vitamins and supplements: _____

For what condition(s)? _____

Are you allergic to any foods or medications? Yes No

If yes, please list: _____

Current diet: Excellent Good Fair Poor

Current state of health (explain): _____

Are there any problems with any of the following? (Please check if there is a history)

	You	Family	Who?		You	Family	Who?
Diabetes	___	___	_____	High Blood Pressure	___	___	_____
Glaucoma	___	___	_____	Cataracts	___	___	_____
Thyroid Disease	___	___	_____	Heart Disease	___	___	_____
Blood Disorder	___	___	_____	Hormone Disorder	___	___	_____
Multiple Sclerosis	___	___	_____	Allergies	___	___	_____
Breathing	___	___	_____	Stomach/Intestines	___	___	_____
Ears/Nose/Mouth	___	___	_____	Blindness	___	___	_____
Amblyopia	___	___	_____	Strabismus	___	___	_____
Brain Tumor	___	___	_____	Cancer	___	___	_____

Is there any other information that you believe would be helpful to the doctor for your evaluation/treatment?

Yes No If yes, explain: _____

Signature of Patient or Guardian

Date