Aaseby Optometry
Douglas H. Aaseby, O.D.

Welcome to Aaseby Optometry!

PATIENT INFORMATION

HOME PHONE__(_____)_____ WORK PHONE__(_____)_____

CELL PHONE __(_____)_____ EMAIL_____

PATIENT

_____

LAST FIRST MI NICKNAME

ADDRESS_____

STREET CITY STATE ZIP CODE

SEX F M DATE OF BIRTH_____/_____/_____ AGE _____

EMPLOYER _____ OCCUPATION _____

SPOUSE / DOMESTIC PARTNER NAME (IF APPLICABLE) _____

INSURANCE INFORMATION

PRIMARY VISION INSURANCE
NAME OF VISION INSURANCE _____

SUBSCRIBER (PERSON WHO CARRIES POLICY): NAME _____ DOB: _____

ID NO OR SOCIAL _____

SECONDARY VISION INSURANCE
NAME OF VISION INSURANCE _____

SUBSCRIBER (PERSON WHO CARRIES POLICY): NAME _____ DOB: _____

ID NO OR SOCIAL _____

MEDICAL INSURANCE
NAME OF MEDICAL INSURANCE _____

SUBSCRIBER (PERSON WHO CARRIES POLICY): NAME _____ DOB: _____

ID NO _____ GROUP NO _____

MEDICAL INFORMATION
PRIMARY CARE PHYSICIAN _____

ADDRESS AND PHONE_____

Do you have any of the following?

EYES	√
Decreased Vision	
Blind spots in vision	
Double/multiple images	
Floating objects	
Flashing lights	
Poor color vision	
Light sensitivity	
Itchy eyes	
Dry & scratchy eyes	
Eye pressure	
Eye pain	
Eye mattering/discharge	
Excessive tearing	
Eye surgeries	
Eye injuries	
Eye Strain	
Headaches	
Blurred vision	

CONSTITUTIONAL	√
Fevers/ chills	
Weight loss/ gain	
Nausea/ vomiting	
Sinus problems	
Hearing loss	
Joint pain/swelling	
Hypertension	
DERMATOLOGICAL	
Skin rash/ dry skin	
CARDIOVASCULAR	
High Blood Pressure	
Heart Disease/Heart attack	
ENDOCRINE	
Diabetes	
Thyroid	
RESPIRATORY	
Lung disease	
Asthma	

FAMILY HISTORY	√	FAMILY MEMBER
Diabetes		
Macular Degeneration		
Cataracts		
Glaucoma		
Blindness		
Other		

Other:_____

Current Medications: (Include eye-drops, prescription, over-the-counter, and dietary supplements)

_____

_____

Allergies to Medications:_____

ALCOHOL PER DAY:_____ **CIGARETTES PER DAY:**_____

PLEASE READ THE FOLLOWING AND SIGN BELOW

INSURANCE POLICY

We are happy to file your vision claims ***as a courtesy to you*** as long as you provide insurance information prior to your appointment. Because of the complexity and variance in insurance and coverage, we strongly advise all patients to be familiar with their coverage. We can guide you, preauthorize treatment, and estimate your cost, but ***it is ultimately your responsibility to fully understand your insurance.*** If your insurance company denies payment you will be financially responsible for payment of all charges

PAYMENT POLICY

We require payment upon services rendered. Copays and overages will need to be paid at the time of service. Regardless of your insurance benefits, payment for services remains your personal responsibility. For your convenience we accept cash, check, Visa, MasterCard, Discover, and Care Credit. There is a $25 fee for returned checks. Sales and coupons are not valid with insurance.

CANCELLATION POLICY

Custom contact lenses and open boxes of contact lenses are non-refundable. Once eyeglass orders have been processed, a $25 handling fee, plus 50% of the usual and customary fees on materials will be charged. Sunglasses may be returned for office credit only within 30 business days. All completed orders are non-refundable. Our office requires a minimum of 24 hours to cancel a scheduled appointment. If an appointment is broken without sufficient notice, a fee of $25 will be assessed.

CONTACT LENS POLICY

An additional exam is offered to patients who wear contact lenses. ***Insurance does NOT include a contact lens exam with the well vision exam.*** This exam is a separate charge in most offices. Our fees for evaluating and fitting contact lenses vary from $40 to $125, depending on whether the fit is for a new wearer, toric, multifocal, soft lens, RGP, etc. Most insurance companies will offer coverage for eyeglasses OR contact lenses, but not both. Contact lens evaluation fees are non- refundable, even if the patient later opts not to wear contacts. A follow up exam is included with contact lens evaluations. ***IF YOU OPT OUT OF HAVING A CONTACT LENS EXAM, YOUR CONTACT PERSCRIPTION CANNOT BE RENEWED.***

I understand that I am responsible for notifying the office of **any changes** in insurance, If I do not provide the current and correct information, I understand that I am responsible for all charges.I am aware that if I **withhold or falsify** insurance information, that I am responsible for all charges.**I have read the above and agree to these terms.**

X _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In the course of providing service to you we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. I have received a copy of this office's Notice of Privacy Practices.

X _____ DATE _____

Thank you for selecting our office to provide you with the very best in vision care. We appreciate your support for small business