ENVISION BOULDER: WELCOME TO OUR OFFICE

Name: _____ Preferred Name: _____ Male / Female / Other

Address: _____ Unit: _____ City: _____ State: _____ ZIP: _____

Preferred Phone: _____ H / W / C Secondary Phone: _____ H / W / C

Date of Birth: _____ Age: _____ Email: _____

How do you prefer to receive appointment reminders? Please check all that apply: email ___ text ___ phone ___

Employer: _____ Occupation: _____ Marital Status: S / M / Other

Please list any family members seen at our office: _____

How did you hear about our office? _____

MEDICAL HISTORY: PLEASE CHECK ONLY BOXES THAT APPLY. UNCHECKED BOXES WILL MEAN "NO."
PLEASE CHECK HERE IF ALL OF THE FOLLOWING ARE "NO." ☐

PERSONAL EYE HISTORY		**PERSONAL MED. HISTORY**	
Conditions	***Y***	***Conditions***	***Y***
Glaucoma/Suspect		Diabetes	
Cataracts		High Blood Pressure	
Macular Degeneration		Elevated Cholesterol	
Uveitis		Thyroid Disorder	
Retinal Detachment		Sleep Apnea	
Lazy Eye/Eye Turn		Heart Disease	
Trauma/Injury		Pregnant (currently)	
Keratoconus		Nursing (currently)	
Other:		Cancer/Type:	
Surgeries	***Y***	Bipolar Disorder	
Cataract		Depression	
Glaucoma		Migraine	
Retinal Detachment		Heart Attack	
LASIK/PRK		Stroke	
Eyelid		HIV/AIDS	
Injections in Eye		Asthma/COPD	
Other:		Kidney Disease	
		Arthritis	
SOCIAL HISTORY	***Y***	Seasonal Allergies	
Smoked in the past		Environmental Allergies	
Current Smoker		Other:	
Drink Alcohol			
FAMILY HISTORY		**WHO?**	
Ocular Conditions	***Y***	**Parents, Siblings, Children**	
Glaucoma/Suspect			
Macular Degeneration			
Retinal Detachment			
Lazy Eye/Eye Turn			
Keratoconus			
Other:			
Medical Conditions	***Y***		
Diabetes			
High Blood Pressure			
Thyroid Disorder			
Heart Disease			
Cancer/Type:			

MEDICATIONS	
Please list all CURRENT medications including eye drops and over the counter medications below.	
MEDICATION	**PURPOSE**

MEDICATION ALLERGIES
Please list any medication allergies below.

Date of last eye exam: _____

Do you currently wear glasses? Y / N

If yes, how old are they? _____

Do you routinely wear sunglasses? Y / N

Do you wear contact lenses? Y / N

If yes, what type? _____

Do you work on a computer? Y / N

If yes, how many hours per day? _____

Privacy Policy:

In the course of providing services 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 services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Envision Boulder.

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

Financial Policy:

Insurance for Eye Care – Medical and Vision Plans

There are two types of health insurance that can help pay for your eye care services and products. You may have both and our practice accepts both; vision care plans (Vision Service Plan or Superior Vision) and medical insurance (Anthem, Blue Cross Blue Shield, Aetna, Cigna, Medicare, etc.).

Vision care plans only cover routine vision exams including refraction (testing for prescriptions) and a basic eye health screening. They do NOT cover diagnoses, management, or treatment of eye disease.

Medical insurance must be used for a patient's eye care visit when the doctor determines a medical diagnosis as the cause of a patient's reason for their visit. Examples include blurred vision, eye pain, eye infections, foreign body removal, sudden onset of flashes and floaters, etc. It also covers visits and additional testing to monitor progressive eye conditions and to determine if a patient's general health issues or medications may be affecting their eyes. Refraction is typically NOT covered by medical insurance.

If you have both types of insurance plans it may be necessary for us to bill some services to your medical insurance and some services to your vision insurance. Insurance carriers set these rules and our office is obligated to follow them. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expenses. Co-pays, deductibles, and non-covered services are the responsibility of the patient.

For patients without insurance or for whom our office is out-of-network we will provide an itemized receipt that can be filed to the carrier or submitted to HSA for reimbursement.

I have read and agree to this policy and authorize Envision Boulder to file my insurance by the above guidelines.

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

Print Patient Name Here: _____