Dr. Nick Martin Eye Care Center
Welcome Back To Our Office

Welcome to Dr. Nick Martin Eye Care Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ___ MI ___ Last Name ___ Preferred Name ___

Street Address ___ City ___ State Zip ___

Social Security Number ___ Date of Birth ___ Home Phone - Include Area Code ___ Work Phone ___

Email Address ___ Guardian ___ Person Responsible for Account ___

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? ___

May our office contact you by? If you wish to be removed from this list you can be at any time.

☐ Text ___ ☐ Cell Phone ___

☐ Email ___ ☐ Home Phone ___

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ___ City ___ State Zip ___

M ☐ F ☐ Insured's First Name ___ MI ___ Insured's Last Name ___

Insured's Identification Number ___ Group Number ___ Insured's Date of Birth ___

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ___ City ___ State Zip ___

M ☐ F ☐ Insured's First Name ___ MI ___ Insured's Last Name ___

Insured's Identification Number ___ Group Number ___ Insured's Date of Birth ___

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : ___

Name

Dr. Nick Martin Eye Care Center
PATIENT HISTORY AND INFORMATION

Race

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ Other Race
- ☐ White
- ☐ Native American
- ☐ Caucasian
- ☐ Refuse To Specify
- ☐ Not Disclosed

Other Race

Ethnicity: ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language: ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Height ___ ft ___ in ___ cm/m ◉ ft in ○ cm ○ m Weight ___ ◉ lbs ○ kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? ____________ When was your last exam ? ____________

When was your last health exam ? ____________

Past Illnesses or Injuries: ____________

Past Surgeries: ____________

Current Medications: ____________

Current Eye Drops: ____________

Medicines that cause reactions or sensitivities: ____________

Specific Allergies: ____________

EYE HISTORY

Condition	Yes	No
Glaucoma	○ Yes	○ No
Cataract	○ Yes	○ No
Macular Degeneration	○ Yes	○ No
Retinal Detachment	○ Yes	○ No
Color Blindness	○ Yes	○ No
Headaches	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No
Tired Eyes	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No
Burning	○ Yes	○ No
Dryness	○ Yes	○ No
Excess Tearing/Watering	○ Yes	○ No
Eye Pain or Soreness	○ Yes	○ No
Foreign Body Sensation	○ Yes	○ No
Infection of Eye or Lid	○ Yes	○ No
Itching	○ Yes	○ No
Mucous Discharge	○ Yes	○ No
Drooping Eyelid	○ Yes	○ No
Redness	○ Yes	○ No
Sandy or Gritty Feeling	○ Yes	○ No
Strabismus (Crossed Eyes)	○ Yes	○ No
Blurred Vision Distance	○ Yes	○ No
Blurred Vision Near	○ Yes	○ No
Distorted Vision (halos)	○ Yes	○ No
Double Vision	○ Yes	○ No
Floaters or Spots	○ Yes	○ No
Fluctuating Vision	○ Yes	○ No
Loss of Vision	○ Yes	○ No
Loss of Side Vision	○ Yes	○ No

Name

Dr. Nick Martin Eye Care Center

GENERAL HEALTH CONDITION

Condition	Response	Condition	Response	Condition	Response
Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Thyroid, Diabetes	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

Condition	Response	Condition	Response	Condition	Response
Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No

Please Read:

The law requires that Dr. Nick Martin The Contact Lens and Eye Care Center make every effort to inform you your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Dr. Nick Martin The Contact Lens and Eye Care Center's Notice of Privacy Practice and agree to continue my care with Dr. Nick Martin The Contact Lens and Eye Care Center under said terms.

☐ I have read or had explained to me Dr. Nick Martin The Contact Lens and Eye Care Center's Notice of Privacy Practice and do not wish to continue my care with Dr. Nick Martin The Contact Lens and Eye Care Center under said terms.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of the other reason described as

____

____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

______________________ Patient

______________________ Date

If you are signing as a personal representative of the patient, please indicate your relationship.

______________________ Representative

______________________ Relationship to Patient

Name

Dr. Nick Martin The Contact Lens and Eye Care Center
Financial Policy
Please Read This in its Entirety and Sign

Thank you for choosing us as your eye care provider. We are committed to your visit being successful and pleasant. Please understand, ALL fees incurred for professional services and materials will be the patients (patient guardian) responsibility regardless of insurance coverage. We will be happy to submit a claim to your insurance company on your behalf, however, insurance companies reserve the right to deny any claim regardless of our attempts to obtain benefits and authorizations. Final determination can only be made when the claim is processed.

We accept all major credit cards, checks, and cash payments. Payments are due at the time of service. Contacts must be paid for at time of order. In the event that your check is returned unpaid, you authorize NorthStar and/or its assignees the right to contact you via home, cell, work phone, E-mail, or letter by mail. A service charge will be assessed, along with any other allowable state fees. Signature of your check constitutes acceptance of these terms. Any account with a balance over 90 days will be turned over to NorthStar, their assignees, and/or the District Attorney for collections. Contacts, prescriptions, and medical records will not be released if there is a balance on the patients account.

Due to the rules imposed on the medical community, it is necessary for all patients to fill out and sign all questions on the welcome form, Privacy Notice, ABN, Financial Policy, and the acceptance and refusal of additional tests. We are required to have a photo ID, medical, and vision insurance cards on file. This allows us to provide you with the best care possible, while protecting your personal information. (See our Privacy Policy) We will not proceed with an exam without this information. Your cooperation is appreciated.

Our fees vary upon services provided. When asked, we quote out discount fee for a basic routine vision screening. This exam includes a glaucoma screening, health evaluation, and a prescription for glasses only.(This does not apply when using insurance or other discount plans.) Contact lens evaluations, Digital Retinal Imaging, Dilation, Computerized Visual Fields, and Medical Exams are additional and will be charged at our usual and customary fees. We can not give an exact quote until after your exam is complete.

We are committed to providing you with the highest level of eye care, but should you experience difficulties in adapting to your new glasses prescription, please return to the optical supplier where you purchased your glasses. Instruct your supplier to verify the lens power, optical center, lens material, seg height, panoscopic tilt, parabolic curve and that the glasses are adjusted properly. Once the optical supplier has determined the accuracy of your prescription and if you're still having issues with your glasses, return to our office immediately. We guarantee our prescriptions up to 60 days from your exam date. After 60 days there will be additional fees.

CONTACT LENSES WEARER PLEASE READ

After your initial contact exam, You are required to return to our office for a follow up evaluation in one weeks time. 45 days of follow up care from the date of your exam is also included. Per Oklahoma state law 505:10-5-14 **Contact lens prescriptions will not be released of finalized before the follow up visit is complete**. If you do not return for your follow up visit and have gone over your 45 day you will be responsible for additional fees. ***No Exceptions!*** *If you know prior to your exam that you will not be able to return for a follow up exam then please inform the doctor.* Please understand, the included follow up care does NOT cover medical visits such as treatment for eye infections. **I have read and understand above statement. Please initial:______**

Payments made by my insurance company are to be paid directly to Dr. Nick Martin Eye Care Center. I understand my insurance will be billed for services rendered. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. I further understand that I am responsible for all charges incurred. I have read and understand the financial policies of Dr. Nick Martin The Contact Lens and Eye Care Center and I agree with these policies.

______________________________ ____________________

Signature Date