Crystal L. Franklin, OD, PA

"We're keeping your world in focus"

Today's date:	Email Address:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell Phone no: ( )	Home phone no.: ( )

Mailing Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Date of Last Eye Exam:

Whom may we thank for referring you (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work	❑ Yellow Pages	❑ Other	❑ Internet	

Reason for visit:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes ❑ No

Please indicate primary insurance	ID#

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

"We are keeping your world in focus"
www.visionsource-drfranklin.com

FLIP PAGE OVER→

Financial Responsibility

The office of Dr. Crystal L. Franklin, OD, PA will gladly file your insurance claim for you when provided with the necessary information to do so. A copy of **ALL** insurance cards will be required to ensure correct billing of services rendered. Additional information may be required if billing issues arise. It is the patient's responsibility to notify the office of any changes in coverage. Payment is required for all services rendered on the date of service. Any delinquent fees are subject to be placed in collections of not paid in a timely manner.

Copays

Most insurance companies require a co-payment for services rendered. As required by your insurance company, the co-payment will be collected on the date of service at the time of check out.

Deductibles

In efforts to help you meet your deductible, we will file your visit with your insurance company to help you reach the annual deductible. ***For Cigna members, if you have an HRA account, the deductible is not applicable and any services filed with your insurance will be paid out of that HRA account.***

Would you like today's services filed towards your deductible?

❑ Yes ❑ No

Medical Insurance

If the deductible is met at the time of service, we will only collect the copay/co-insurance that the patient is responsible for. If you HAVE NOT met your deductible with your insurance company, we will collect 100% of the charges at the time of service at checkout.

Medicaid

Medicaid Plans including (First Choice/Select Health, March Vision, Molina, Advicare, Absolute Total Care, and Blue Choice) are accepted except for family planning which does **NOT** cover vision services. A cop-payment in the amount of $3.30 is **REQUIRED** for adults over the age of 20 and have to be paid when services are rendered.

Medicare

Medicare has an annual deductible that has to be met at the time of service. If this deductible is not met, we will collect 100% of the charges at the time of service and this amount will be filed to help meet the annual deductible. If this deductible is met, we will gladly file your claim with Medicare. Medicare will then pay 80% of the charges and you the patient is responsible for the remaining 20% unless indicated by a secondary plan. The refraction is **NOT** covered by Medicare and/or secondary policies because it is a vision service, therefore all Medicare patient will have to pay the $35 refraction charge.

Financial Agreement

I, the patient, acknowledge that payment for all services rendered at the time of service. I agree that parents, guardians, or personal representatives are responsible for ALL fees and services rendered for treatment of a minor aged 16 and above. I fully accept full responsibility for ALL charges or items provided to me, my child, or the patient for whom I have legal responsibility. I understand that filing a claim with my insurance does NOT guarantee payment or exempt me from my responsibility for the payment of ALL charges, i.e. if a claim is denied by the insurance company, I understand that I WILL be billed and is responsible for paying the total amount due.

____________________________________ ________________________
Patient/Guardian Signature Date

FLIP PAGE OVER→

Medical History

Do you have any allergies to medications? ❑Yes ❑No If yes, please explain ________________________

Do you have any other allergies? ❑Yes ❑No If yes, please explain _________________________________

List all medications that you take: ____
____

List all make injuries, surgeries, and/or hospitalizations you have had:
____
____

Check any of the conditions that you have or have had in the past: ❑Reading Difficulty ❑Crossed Eyes

❑Glaucoma ❑Lazy Eye ❑Retinal Disease ❑Cataracts ❑Eye Injury ❑Light Sensitivity

Do you currently wear glasses? ❑Yes ❑No

Do you currently wear contact lenses? ❑Yes ❑No
Brand of lenses? ___________________________________ Hours per day? _______________

Have you had any eye surgeries? ❑Yes ❑No Type of surgery? _________________________

Do you have trouble reading signs when driving at night? ❑Yes ❑No

Social History

Are you currently pregnant or nursing? ❑Yes ❑No

Do you use tobacco products? ❑Yes ❑No If yes, explain type/amount/how long: ________________________

Do you drink alcohol? ❑Yes ❑No If yes, explain type/amount/how long: ___________________________________

Do you use recreational drugs? ❑Yes ❑No If yes explain type/amount/how long: ___________________________

Have you ever been infected with or exposed to STD's such as:

❑Gonorrhea ❑Hepatitis ❑HIV/AIDS ❑Syphilis ❑Herpes ❑Have never

Family History

Have any of your relatives, living or deceased, suffer from any of these conditions?

Condition	Yes	No	Not Sure	Relation to you
Blindness	❑	❑	❑	____________
Cataract	❑	❑	❑	____________
Crossed Eyes	❑	❑	❑	____________
Glaucoma	❑	❑	❑	____________
Macular Degeneration	❑	❑	❑	____________
Retinal Disease/Detachment	❑	❑	❑	____________
Arthritis	❑	❑	❑	____________
Cancer	❑	❑	❑	____________
Diabetes	❑	❑	❑	____________
Heart Disease	❑	❑	❑	____________
High Blood Pressure	❑	❑	❑	____________
Kidney Disease	❑	❑	❑	____________
Lupus	❑	❑	❑	____________
Thyroid Disease	❑	❑	❑	____________
Other	❑	❑	❑	____________

Dilation

Dilating your eyes allows Dr. Franklin to examine the entire retina (the back of the eye) that enables you to see. Without dilation, less than 30% of the back of the eye can be examined. Dilation allows the doctor to check the health and detect the presence of eye disease. In order to be dilated, drops would need to be placed in your eyes to make the pupil larger. It takes approximately 3-6 hours. A driver is recommended. A dilation is recommended at least every two years, unless otherwise specified by your eye care physician. Getting dilated is your decision unless there is an eye problem that requires the doctor to dilate you. There is <u>NO</u> additional fee for dilation.

Would you like to be dilated today? ❑Yes ❑No

Optomap Retinal Image

At this office, we strive to provide our patients with the latest technology. While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a through screening of the retina is critical to verify that your eye is healthy. This can lead to the detection of common diseases, such as glaucoma, diabetes, macular degeneration, and even types of cancer. This exam is quick, painless, non-invasive, and ***<u>does not</u>*** require dilation drops. The Optomap image is not necessarily a replacement for dilation, but can be used as an alternative without the effects of dilation such as temporary near vision loss and light sensitivity. The Optomap image is **<u>NOT</u>** covered by vision insurance. It is an out of pocket fee of $39.00. However, if there is an eye problem detected, the Optomap image can be filed with your health insurance is the deductible has been met.

Would you like the Optomap Retinal Image today? ❑Yes ❑No

Review of Systems

System	Yes	No
Cancer	☐	☐
Cardiovascular/Vascular		
Heart Pain	☐	☐
Hypertension	☐	☐
Elevated Cholestrol	☐	☐
Arrhythmia	☐	☐
Myocardial Infarction	☐	☐
Constitutional		
Blackouts	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Endocrine		
Diabetes A1C:______	☐	☐
Thyroid Disorder	☐	☐
Crohn's Disease	☐	☐
Renal Disease	☐	☐
Gout	☐	☐
Gastrointestinal		
Acid Reflux	☐	☐
Cirrhosis	☐	☐
Diarrhea	☐	☐
Gastritis	☐	☐
Ulcers	☐	☐
Genitourinary		
Kidney Disorder	☐	☐
Bladder Issues	☐	☐
Genitals	☐	☐
Menopause	☐	☐
Pelvic Inflammatory Disease	☐	☐
Ear, Nose, Mouth, and Throat		
Seasonal Allergies	☐	☐
Sinusitis	☐	☐
Chronic Cough	☐	☐
Meniere's Syndrome	☐	☐
Encephalitis	☐	☐

System	Yes	No
Hematologic/Lymphatic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Breast Carcinoma	☐	☐
Hodgkin's Disease	☐	☐
Leukemia	☐	☐
Sickle Cell Disease	☐	☐
Varicose Veins	☐	☐
Immunologic		
Sjogren Disease	☐	☐
AIDS/HIV	☐	☐
Chicken Pox	☐	☐
Herpes Simplex	☐	☐
Herpes Zoster	☐	☐
Lyme Disease	☐	☐
Reye's Syndrome	☐	☐
Tubeculosis	☐	☐
Integumentary		
Acne	☐	☐
Rosecea	☐	☐
Dermatitis	☐	☐
Eczema	☐	☐
Impetigo	☐	☐
Lupus	☐	☐
Psoriasis	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Skeletal Disorder	☐	☐
Marfan's Syndrome	☐	☐
Myasthenia Gravis	☐	☐
Neurological		
Headaches/Migraines	☐	☐
Seizures	☐	☐
Brain Injury/Stroke	☐	☐
Bell's Palsy	☐	☐
Parkinson's Disease	☐	☐
Cerebral Palsy	☐	☐

System	Yes	No
Psychiatric		
ADD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Dementia	☐	☐
Bi-Polar	☐	☐
Personality Disorder	☐	☐
Learning Disability	☐	☐
Autism	☐	☐
Alzheimer's Disease	☐	☐
Respiratory		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Lung Disorder	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision	☐	☐
Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Muscous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Tearing/Watering	☐	☐
Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Stye/Chalazion	☐	☐
Flashes/Floaters	☐	☐
Eye Fatigue	☐	☐