

S I G H T L I N E

Laser Eye Center & Ophthalmic Associates

2591 WEXFORD-BAYNE ROAD, SUITE 104 SEWICKLEY, PA 15143 P (724) 933-5588 F (724) 933-6051

Welcome to our office!

Your doctor has referred you to our office for testing. We are honored that your doctor has selected us to participate in your care.

Testing is often ordered to help diagnose a condition. If the testing does not reveal a covered diagnosis, your insurance company may determine that it is not medically necessary. Health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. When you receive an item or service that is not a covered benefit, you are responsible to pay for it at the time of service. The cost for testing services usually ranges from \$50 to \$100 per test.

Please complete both sides of the **HEALTH HISTORY FORM**. This will shorten your time in the office. If you have any trouble completing this information, someone from our office will be happy to help you at the time of your visit. Please bring your form and your **MEDICAL INSURANCE CARD(S)** with you to your appointment.

Do not hesitate to call our office if you have any questions. We look forward to meeting you!

Sincerely,

The SightLine Doctors & Staff

Serving Eye Doctors & Their Patients

WEXFORD ◦ CHIPPEWA ◦ PLEASANT HILLS ◦ NEW CASTLE ◦ KITTANNING

HEALTH HISTORY

Patient Information

Patient Name _____ D.O.B. ____/____/____
Address _____
City _____ State _____ Zip Code _____
Social Security# _____ - _____ - _____ Home Phone _____
Work Phone _____ Cell Phone _____
Employer _____ Occupation _____
Emergency Contact Name _____ Relation _____
Emergency Contact Phone _____ Eye Doctor _____
Family Doctor _____ Family Doctor Phone _____
Preferred Pharmacy _____ Phone/Location _____

Social History

Does your vision limit any activities of daily living? (please check)

driving reading sports work other _____

Do you drink alcohol? No / Yes How often? _____

Do you smoke? No / Yes How much? _____ For how many years? _____

Family History

Is there any family history of the following? (please circle) If yes, list family member:

Blindness No / Yes _____ Cataract No / Yes _____

Glaucoma No / Yes _____ Diabetes No / Yes _____

Macular Degeneration No / Yes _____

Past Visual & Medical History

Have you ever had any eye injuries or surgeries? No Yes If yes, please list them and the approximate year:

Have you ever had any other surgeries? No Yes If yes, please list them and the approximate year:

Do you have any history of cancer? No Yes If yes, please explain:

please complete other side

NAME _____

Please list any medications and why you are taking them:

Have you ever taken medications for enlarged prostate (Flomax, Tamsulosin, etc)? No Yes

Are you allergic to any latex products? No Yes

Are you allergic to any medications? No Yes, please list: _____

Do you use oxygen? No Yes, only at night Yes, all the time

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic

- drug allergy
- environmental allergy
- other allergy
- rheumatoid arthritis
- lupus
- other _____
- NONE

Lungs/Breathing

- cigarette smoker
- asthma
- bronchitis
- COPD
- emphysema
- sleep apnea CPAP: Y N
- other _____
- NONE

Endocrine

- non-insulin diabetic
- insulin diabetic
- thyroid dysfunction
- hormonal dysfunction
- pregnant/breastfeeding
- other _____
- NONE

Eyes

- glaucoma
- cataracts
- macular degeneration
- inflammatory disorders
- previous surgery
- other _____
- NONE

Gastrointestinal

- Crohn's
- colitis
- ulcer
- digestive problems
- other _____
- NONE

Cardiovascular

- heart disease
- defibrillator
- high blood pressure
- stroke
- poor circulation
- high cholesterol
- other _____
- NONE

Musculoskeletal

- arthritis
- muscular dystrophy
- fibromyalgia
- ankylosing spondylitis
- other _____
- NONE

Genitourinary

- STD
- urinary problems
- prostate problems
- other _____
- NONE

Neurological

- multiple sclerosis
- epilepsy
- other _____
- NONE

Skin

- eczema
- rosacea
- psoriasis
- other _____
- NONE

Constitutional

- developmental disability
- sudden weight loss
- fatigue
- trauma
- other _____
- NONE

Psychiatric

- depression / anxiety
- panic disorder
- schizophrenia
- dementia/alzheimer's
- other _____
- NONE

Blood/ Lymphatic

- leukemia
- anemia
- large volume blood loss
- other _____
- NONE

Ear, Nose, Throat

- upper respiratory tract infection
- other _____
- NONE

For Office Use Only

Medical History Updates:

Date: _____

Tech Initials: _____

Doctor Initials: _____

Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
HEIGHT _____	WEIGHT _____	BMI _____	

SightLine Laser and Ophthalmic Associates
**ADVANCE NOTICE & ACKNOWLEDGEMENT OF
POLICIES**

HIPAA PRIVACY POLICY

A copy of our Notice of Privacy Practices is posted at the front desk and can be found in our 'Privacy Binder'. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

REFRACTIONS

A refraction may be performed at your evaluation and/or subsequent follow-up visits. This is a test to determine the best possible vision. This test is a separate component to the medical exam and is NOT COVERED BY INSURANCE PLANS. Our current fee for this service is \$45.00. If you choose to pay for the refraction on the day of service, a \$10 cash discount will be extended.

ASSIGNMENT OF BENEFITS

Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to SightLine Ophthalmic Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY

Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from SightLine Ophthalmic Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred in the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

Patient Name (print)

Signature

Date