HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
Phone: 402-493-6500 ○ Fax: 402-493-4370

To Our Valued Patient:

Welcome to Heartland Eye Consultants! We are looking forward to seeing you for your appointment. Attached you will find the New Patient Paperwork. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. Please bring them with you to your appointment.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms
2. Your insurance card
3. Your co-pay
4. A list of any medications you take with the dosages
5. Your glasses (Even if you do not typically wear them)

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be submitting a claim to your major medical insurance, not your 'vision' or 'eye glasses' insurance.

If your insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking on the west side of the building will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402) 493-6500. Thank you for entrusting your vision to us!

Sincerely,
Patient Services

Heartland Eye Consultants
Adult Patient Demographics

Patient:
Last Name: _____ First Name: _____ M.I. _____

Street Address: _____ Apt #_____ Gender: ☐ M ☐ F Date of Birth: _____/_____/_____

City: _____ State: _____ Zip Code: _____ Soc. Sec. No. _____-_____-_____

Cell: (_____) _____ Home: (_____) _____ Work: (_____)_____EXT_____

Please provide your email address for appointment purposes only: **Email:**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other_____ ☐ I decline.

Race: ☐American Indian or Alaska Native ☐Asian ☐African-American ☐Pacific Islander ☐White ☐Other Race ☐ I decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other_____ ☐ I decline to answer this question.

Special Needs: ☐ Hearing Impaired ☐ Wheelchair ☐ Translator ☐ None ☐ Other_____

Occupation: _____ Employer: _____

Employer's Address: _____ City, State, Zip: _____

Is this visit a result of an accident or illness *that occurred at work*? ☐ Yes ☐ No

Were you referred to our office by a doctor or doctor's office? ☐Yes ☐No If yes, who? _____

Who performed your last eye exam? _____ Date: _____/_____/_____

Family Physician: _____ Approx Location: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
(Not living in household) (Area Code)

If the patient is married, please complete spouse information:

Spouse's Last Name:_____First Name:_____ M.I.____ Birthdate: _____/_____/_____

Cell Phone: _____ Work Phone: _____EXT_____ **Email** _____

SSN:_____ Employer: _____ Occupation_____Title: _____

Employer's Address:_____ City_____ State_____Zip_____

The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card.
For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment:
Cash Check Credit Card (Mastercard or Visa. We do not accept Discover or American Express)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and that 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 In the event you fail keep your appointments or if you repeatedly reschedule your appointment with less than a 48 hour notice, a $50 deposit may be required prior to scheduling another appointment. This deposit will be credited to your bill if you keep the appointment as scheduled. If you fail to keep the appointment or reschedule again with less than 48 hour notice, you will forfeit the deposit.

****I authorize communication of my medical records to be released to: _____**

Authorized Signature: _____Date of Signature: _____
PLEASE INITIAL _____ You have read and are aware of the HIPAA privacy policy and agree with its provisions.

DRY EYE QUESTIONNAIRE

Please answer the following questions by checking the box that best represents your answer.
Select only **one** answer per question.

1. Report the type of **SYMPTOMS** you experience and when they occur:

SYMPTOMS	TODAY		WITHIN PAST 72 HOURS		WITHIN PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the **FREQUENCY** of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the **SEVERITY** of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** _____

SCORE:_____/ 28_

NAME: _____ DATE:_____