WELCOME TO SHANNON VISION CARE

LAST NAME: _____ FIRST NAME: _____ M.I. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SSN: _____ ( ) MALE ( ) FEMALE

HOME PHONE: ( ) _____-_____ CELL PHONE: ( ) _____-_____ WORK PHONE: ( ) _____-_____

EMAIL: _____@_____

( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) OTHER RACE: _____ ETHNICITY: _____

EMPLOYER: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? _____

PLEASE CIRCLE ONE:

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? YES NO TEXT OK? YES NO

PREFERRED METHOD OF COMMUNICATION: _____ EMAIL OK? YES NO

WOULD YOU LIKE TO OPT INTO PATIENT PORTAL? YES NO

*OUR PATIENT PORTAL IS A SECURE ONLINE WEBSITE THAT GIVES PATIENTS CONVENIENT ACCESS TO THEIR PERSONAL HEALTH INFORMATION FROM ANYWHERE USING A SECURE USERNAME AND PASSWORD.

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MEDICAL INSURANCE CARRIER: _____ PRIMARY CARDHOLDER: _____

RELATION TO PATIENT: _____ INSURED DOB: _____/_____/_____ SSN: _____

*IF A **MEDICAL DIAGNOSIS** (*CATARACTS, GLAUCOMA SUSPECT, DIABETES, PINK EYE-CONJUNCTIVIS, FOREIGN BODY, ETC.*) IS DETERMINED BY THE DOCTOR THE PATIENT'S EXAM IS CONSIDERED MEDICAL. THIS MEANS SHANNON VISION CARE WILL BILL YOUR HEALTH (MEDICAL) INSURANCE. WE REQUEST A COPY OF YOUR MEDICAL CARD IN YOUR CHART FOR THESE REASONS.

VISION INSURANCE CARRIER: _____ PRIMARY CARDHOLDER: _____

RELATION TO PATIENT: _____ INSURED DOB: _____/_____/_____ SSN: _____

* **ROUTINE VISION EXAMS** WILL BE FILED WITH THE PATIENTS VISION PLAN IF YOU HAVE ONE. A ROUTINE EYE EXAM MEANS THERE IS NOT A MEDICAL DIAGNOSIS. ROUTINE DIAGNOSIS IS MYOPIA (NEAR-SIGHTEDNESSS), HYPEROPIA (FAR-SIGHTEDNESS), ASTIGMATISM, AND PRESBYOPIA.

****

IF YOU HAVE ANY OTHER CONCERNS OR QUESTIONS TODAY FOR THE DOCTOR PLEASE DOCUMENT BELOW:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL & OPTICAL QUESTIONNAIRE

REASON FOR THIS VISIT? : _____

WHEN WAS YOUR LAST EYE EXAM? : _____

PRIMARY CARE PHYSICIAN: _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES (INCLUDE MEDICATION ALLERGIES): _____

MAJOR SURGERIES (EYE OR OTHER): _____

ARE YOU INTERESTED IN LASIK EYE SURGERY?	YES	NO	
DO YOU USE TOBACCO?	YES	NO	SOCIAL
DO YOU DRINK ALCOHOL?	YES	NO	SOCIAL

FAMILY MEDICAL HISTORY:

***PLEASE LIST ONLY IMMEDIATE RELATIVES IF APPLICABLE**

CATARACTS	RELATIVE _____	HEART DISEASE	RELATIVE _____
GLAUCOMA	RELATIVE _____	DIABETES	RELATIVE _____
MACULAR DEGENERATION	RELATIVE _____	BLINDNESS	RELATIVE _____
RETINAL DETACHMENT	RELATIVE _____	HIGH BLOODPRESSURE	RELATIVE _____
HEART ATTACK	RELATIVE _____	HIGH CHOLESTEROL	RELATIVE _____
THYROID	RELATIVE _____	CANCER	RELATIVE _____

DO YOU HAVE ANY OF THE FOLLOWING?

HEADACHES/MIGRANES	YES	NO
DOUBLE VISION	YES	NO
DRY/ BURNING EYES	YES	NO
ITCHY EYES (SEASONAL)	YES	NO
ALLERGIES	YES	NO
LAZY EYE	YES	NO
GLARE/ SENSITIVITY TO LIGHT	YES	NO
EYE SURGERY	YES	NO
FLOATERS/ FLASHES OF LIGHT	YES	NO
CATARACTS	YES	NO
GLAUCOMA	YES	NO
MACULAR DEGENERATION	YES	NO
DIABETES	YES	NO
HIGH BLOODPRESSURE	YES	NO
HIGH CHOLESTEROL	YES	NO
THYROID DISORDER	YES	NO

CONTACT LENSES & DRY EYE QUESTIONNAIRE

1) WHAT TYPE OF CL DO YOU WEAR? _____

2) RATE YOUR COMFORT (1-5) _____

3) WHAT SOLUTION DO YOU USE? _____

4) DO THEY FEEL DRY NOW? _____

5) DO YOU PUT DROPS IN YOUR EYES? _____

6) WHAT DROPS DO YOU USE? _____

7) HOW MANY HOURS PER DAY ARE CL WORN? _____

8) DO YOUR EYES EVER ITCH, BURN, OR WATER? _____

9) HOURS OF COMPUTER USE PER DAY? _____

EYE WEAR QUESTIONNAIRE

1) DO YOU WEAR EYE GLASSES? _____

2) HOW OLD ARE YOUR GLASSES? _____

3) DO YOU OWN MORE THAN ONE PAIR OF GLASSES? _____

4) DO YOU PLAN TO LOOK FOR NEW GLASSES TODAY? _____

5) DO YOU SPEND A LOT OF TIME ON THE COMPUTER? _____

6) SPORTS/HOBBIES? _____

SHANNON VISION CARE
ACKNOWLEDGE OF FINANCIAL POLICY AND NOTICE OF PRIVACY POLICY

FINANCIAL POLICY

Shannon Vision Care is committed to caring for our patient's complete ocular health. Here at Shannon Vision Care our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Dr. Shannon is trained to diagnosis and treat most ocular diseases.

Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. **This includes services provided for a minor patient**. We prefer payment in full when ordering glasses or contacts. We accept cash, local checks, Visa, MasterCard, Discover and Care Credit.

We are panel providers and accept assignment on several vision and medical plans. This means that at the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance company for covered services. **You will be responsible for any remaining balance**.

If you need a referral from your primary provider to see us, **it is your responsibility to obtain that referral prior to your examination**. A referral with an authorization number is not a promise to pay for that visit. If for some reason you were not eligible for services at the time of the examination, your HMO, PPO or IPA may deny payment and you will still be responsible. Please realize that: 1.) Your insurance coverage is a contract between you and your insurance company. 2.) Not all services are a covered benefit in all contracts and routine eye care and other selected procedures may be specifically excluded, making the patient responsible for the charges. We will try to furnish you with as much information as we can before you select a treatment option so that you can make the most informed decision possible. We don't like surprises either!

We must emphasize that as eye care professionals, our relationship is with you and not your insurance company. You are ultimately responsible for all fees for both services and materials delivered to you by this office. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or your insurance coverage, please do not hesitate to ask. We are here to help you. Thank You! Please sign below to acknowledge that you understand this policy.

PATIENT SIGNATURE DATE

HIPAA NOTICE OF PRIVACY POLICY

The law requires that Dr. Bridget Shannon and Shannon Vision Care make every effort to inform you of your rights related to personal health information. Attached on your clipboard is our laminated **NOTICE of PRIVACY PRACTICES**.

I acknowledge that (Please check one option below):

- o **(AGREE)** I was given the opportunity to read Dr. Bridget Shannon and Shannon Vision Care's Notice of Privacy Practices and ***do wish to continue in my care*** under said terms.
- o **(DISAGREE)** I have read or had explained to me Dr. Bridget Shannon and Shannon Vision Care's Notice of Privacy Practices and ***do not wish to continue my care*** under said terms.

I HAVE READ AND UNDERSTAND OUR NOTICE OF PRIVACY PRACTICES. I AM SIGNING THIS VOLUNTARILY.

PATIENT SIGNATURE DATE

Patient or parent if patient is a minor