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LEADING EDGE EYECARE
3950 TECPORT DRIVE, #170
HARRISBURG, PA 17111
(717) 564-5211
WWW.LEADINGEDGEEYECARE.COM
MEMBER *VISION SOURCE* NETWORK

Welcome to Leading Edge Eyecare

Our doctors and staff welcome you to Leading Edge Eyecare. We consider your questions, needs, comfort and confidence in our office and staff our top priority. Our services are provided with professionalism, representing the latest technology and highest quality eyeglasses and contact lenses. All of our staff and doctors actively update their education in the most current medical research and clinical procedures.

When you arrive at our office for your exam, please bring the following:

- Completed "Welcome Packet" for each person being seen
- Any glasses that you own, including sunglasses or over the counter glasses
- Contact lens boxes, vials, or previous prescription
- Your current *medical* insurance card and vision insurance card
- Any eye drops that you use
- A list of current medications
- A list of questions that you may have for the staff or doctors
- If you are able to get your previous record it is helpful, but not required.

Cancellation/No Show Policy

In an effort to make sure that we are able to serve all of our patients in an efficient manner, we have instituted a policy regarding appointment cancellation and no-shows. If you cancel your appointment with less than 24 hours notice or you do not show up for a scheduled appointment, we reserve the right to charge a \$25 fee to your account. You will be responsible for paying this charge before you are seen for your next appointment.

Please take this into consideration when you are making the appointment. We have reserved this time especially to take care of your visual needs. Thank you for your attention in this matter.

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Street _____

City _____ State _____ Zip _____

Patient's SSN _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Preferred method of contact: H / W / C / E-mail

Patient Date of Birth _____ Age _____

Gender M F Marital Status: S M D W

Employer (or School) _____

Occupation (or Grade) _____

Spouse/Parent Name _____

Spouse/Parent Work Phone _____

Spouse/Parent Date of Birth _____

What is the major purpose of this visit?

Any concerns with your current contact lenses or glasses?

Are you interested in trying contact lenses for the first time or returning to contact lens wear? Yes No

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name: _____

If not referred, how did you choose our office?
 Another Eye Doctor Insurance List
 Saw Sign/Building Vision Source
 Your Physician Yellow Book
 Verizon Yellow Pages
 Web: _____
 Other _____

Financial Information

Please be aware that many insurances do not cover contact lens evaluations, refractions, or additional procedures.

Do you participate in a flex spending account?

Yes No

Who is responsible for payment on this account?

This patient Parent

Other, please specify:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Lifestyle and Diagnostic Information

Do you.....(check box if your answer is yes)

- work at a computer? If yes, how many hours per day and what type of screen is used:
- think you might benefit from thinner, lighter lenses?
- have interest in a "test drive" of the latest contact lens designs?
- spend time outdoors? How much? _____ Hrs/week
- have prescription sunglasses?
- prefer not to wear your glasses at times?
- want information on Laser Vision Correction surgery?
- play sports? If so, which sports? _____
- have more than 1 pair of current Rx eyewear?
- have children?
- have family members in need of eye care?
- have an east/west commute?
- difficulty reading, lose place during reading, or have to re-read the same line over and over?

Our Mission:

Caring for eyes and the people behind them . . .

The doctors and staff of Leading Edge Eyecare promise every patient that:

- **You matter. Your questions, needs, comfort and confidence in our staff are our top priorities.**
- **Our services are provided with professionalism, representing the latest technology and highest quality eyeglasses and contact lenses.**
- **All of our staff and doctors actively update their education in the most current medical research and clinical procedures.**

PLEASE MAKE SURE THAT YOU FILL OUT BOTH SIDES OF THIS FORM

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Family Physician _____ Town _____ Phone Number _____ Date of Last Physical / Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____ _____		
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____		
Have you had any <i>recent</i> surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social History: Do you use... <input type="checkbox"/> Cigarettes/tobacco If so, how much? <input type="checkbox"/> Less than a pack/day <input type="checkbox"/> About a pack/day <input type="checkbox"/> 2 packs/day <input type="checkbox"/> More than packs/day <input type="checkbox"/> When did you start smoking/using tobacco? _____		
<input type="checkbox"/> Alcohol: <input type="checkbox"/> Social only <input type="checkbox"/> 1-2 drinks daily <input type="checkbox"/> More <input type="checkbox"/> Illegal substances? What? <input type="checkbox"/> None		
Have you been diagnosed or treated for the following health problems? <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Allergies <input type="checkbox"/> Blood/Lymph <input type="checkbox"/> Cancer (type _____) <input type="checkbox"/> Digestive <input type="checkbox"/> Ears/Nose/Throat <input type="checkbox"/> Eczema/Rashes <input type="checkbox"/> Fevers <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney <input type="checkbox"/> Neurological <input type="checkbox"/> Respiratory <input type="checkbox"/> Throat Infections <input type="checkbox"/> Unusual weight loss/gain <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes: Average Blood Sugar _____ Last Hemoglobin test _____ % (long term blood sugar test) </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cholesterol <input type="checkbox"/> Asthma <input type="checkbox"/> Endocrine <input type="checkbox"/> Fatigue <input type="checkbox"/> Genitourinary <input type="checkbox"/> Skin problems <input type="checkbox"/> Muscle/Bone <input type="checkbox"/> Psychological <input type="checkbox"/> Sinus <input type="checkbox"/> Thyroid <input type="checkbox"/> Migraines </td> </tr> </table>	<input type="checkbox"/> Allergies <input type="checkbox"/> Blood/Lymph <input type="checkbox"/> Cancer (type _____) <input type="checkbox"/> Digestive <input type="checkbox"/> Ears/Nose/Throat <input type="checkbox"/> Eczema/Rashes <input type="checkbox"/> Fevers <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney <input type="checkbox"/> Neurological <input type="checkbox"/> Respiratory <input type="checkbox"/> Throat Infections <input type="checkbox"/> Unusual weight loss/gain <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes: Average Blood Sugar _____ Last Hemoglobin test _____ % (long term blood sugar test)	<input type="checkbox"/> Arthritis <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cholesterol <input type="checkbox"/> Asthma <input type="checkbox"/> Endocrine <input type="checkbox"/> Fatigue <input type="checkbox"/> Genitourinary <input type="checkbox"/> Skin problems <input type="checkbox"/> Muscle/Bone <input type="checkbox"/> Psychological <input type="checkbox"/> Sinus <input type="checkbox"/> Thyroid <input type="checkbox"/> Migraines
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Patient Eye History																																
Date of Last Eye Exam _____ By Whom? _____																																
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Contact Lens Wear Information (skip if not applicable)																																
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____																																
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THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INFORMATION!

PLEASE MAKE SURE THAT YOU FILL OUT BOTH SIDES OF THIS FORM

Notice of Privacy Practices Acknowledgement
Leading Edge Eyecare and Pease-Sieber Eye Associates, P.C.
3950 TecPort Drive, Suite 170, Harrisburg, PA 17111

I understand that, under the Healthcare Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received or have waived receipt of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

PRINT: Patient Name: X _____

SIGN: Patient Signature: X _____ Relationship: _____

Date: X _____

Access to my medical record and/or Personal Health information is granted to: _____

SIGN: Patient Signature: X _____

Assignment and Release (Signature on File)

I certify that I and/or my dependent(s), have insurance coverage and assign directly to Pease-Sieber Eye Associates, (doing business as Leading Edge Eyecare) all insurance benefits, if any, otherwise payable to me for services rendered.

____ (Initial) I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Pease-Sieber Eye Associates, P.C., (doing business as Leading Edge Eyecare), may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PATIENT SIGNATURE

DATE

RELATIONSHIP TO PATIENT

CANCELLATION / NO-SHOW POLICY

In an effort to make sure that we are able to serve all of our patients in an efficient manner, we have instituted a new policy regarding appointment cancellation and no-shows. If you cancel your appointment with less than 24 hours notice or you do not show up for a scheduled appointment, we reserve the right to charge a \$25 fee to your account. You will be responsible for paying this charge before you are seen for your next appointment.

Please take this into consideration when you are making your appointment. We have reserved this time especially to take care of your visual needs. Thank you for your attention in this matter.

Please sign below to indicate that you have read and understand this policy.

PATIENT SIGNATURE

DATE

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