Leading Edge Eyecare

LEADING EDGE EYECARE
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(717) 564-5211
WWW.LEADINGEDGEEYECARE.COM
MEMBER VISION SOURCE NETWORK

Audra W. Sieber, O.D.
Optometrist
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Optometrist

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? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any *recent* surgeries? ❑ Yes ❑ No

Social History: Do you use…
❑ Cigarettes/tobacco
If so, how much? ❑ Less than a pack/day
❑ About a pack/day
❑ 2 packs/day
❑ More than packs/day
❑ When did you start smoking/using tobacco?
_____
❑ Alcohol: ❑ Social only ❑ 1-2 drinks daily ❑ More
❑ Illegal substances? What?
❑ None

Have you been diagnosed or treated for the following health problems?

❑ Allergies	❑ Arthritis
❑ Blood/Lymph	❑ Bronchitis
❑ Cancer (type _____)	❑ Cholesterol
❑ Digestive	❑ Asthma
❑ Ears/Nose/Throat	❑ Endocrine
❑ Eczema/Rashes	❑ Fatigue
❑ Fevers	❑ Genitourinary
❑ High Blood Pressure	❑ Skin problems
❑ Kidney	❑ Muscle/Bone
❑ Neurological	❑ Psychological
❑ Respiratory	❑ Sinus
❑ Throat Infections	❑ Thyroid
❑ *Unusual* weight loss/gain	❑ Migraines
❑ Seizures	

❑ Diabetes: Average Blood Sugar _____
Last Hemoglobin test _____ %
(long term blood sugar test)

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flashes of light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable glasses	
❑ Other eye disorders_____	

Contact Lens Wear Information (skip if not applicable)

Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship (who? Maternal or Paternal side?)
Systemic:	
Diabetes	❑_____
Heart Disease	❑_____
High Blood Pressure	❑_____
High Cholesterol	❑_____
Eye-related:	
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Glaucoma	❑_____
Lazy Eye/Amblyopia	❑_____
Eye Turn/Strabismus	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

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

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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**	**RELATIONSHIP TO PATIENT**