DRS. AUDRA SIEBER & JANE FORTE, OPTOMETRISTS
3950 TECPORT DRIVE, SUITE 170
HARRISBURG, PA 17111
717-564-5211 PHONE
717-564-5280 FAX
leadingedgeeyecare@comcast.net

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" (attached) for each person being seen;
- Any glasses that you own, including sunglasses or over-the-counter glasses;
- Contact lens boxes, vials, or your previous prescription;
- Your current ***medical*** insurance card(s) and vision insurance card;
- Your driver's license or identification card;
- Any eye drops that you use (even if you do not use them daily or all year-round);
- A list of your current medications;
- A list of questions that you may have for the staff or doctors;
- If you are able to secure and bring your previous records it is helpful for the doctors, but not required.

We look forward to meeting you.

Dr. Sieber & Dr. Forte
Phone: 717-564-5211
Fax: 717-564-5280
Email: Leadingedgeeyecare@comcast.net

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 an appointment cancellation/no-show policy. If you cancel your appointment with less than 24 hours' notice, do not show up for an appointment, OR consistently reschedule your 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.

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

Welcome to our office!

Today's Date _____

PATIENT INFORMATION

Last Name _____
First Name _____ MI _____
Street Address _____
City _____ State ____ Zip _____
Patient SSN _____
Patient Date of Birth _____
Gender: M F Marital Status: S M D W
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

We use text and email to notify you of appointments and when you have orders ready. You *will not* receive written mail correspondence for this purpose.
May we text/email you? ❑ YES ❑ NO

Employer/School _____
Occupation/Grade _____
Spouse/Parent Name _____
Spouse/Parent Phone _____
Spouse/Parent Date of Birth _____

What is the major purpose of this visit?

_____

_____

Do you have any concerns with your current glasses and/or contact lenses? _____

_____

_____

Are you interested in trying contact lenses for the first time or returning to contact lens wear? ❑ YES ❑ NO

New Patients Only:

Were you referred to our office? If so, by whom?

Name: _____

If not referred, how did you choose our office?
❑ Another Eye Doctor ❑ Insurance List
❑ Saw sign/building ❑ Vision Source
❑ Your Physician ❑ 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 Health Savings Account (HSA) or Flexible Spending Account (FSA)? ❑ YES ❑ NO

Who is responsible for payment on this account? (This will frequently be the guarantor for your insurance.)

❑ The patient ❑ Parent ❑ Other

Please complete the following if you selected "Other" above:
Name: _____
Relationship to patient: _____
Address (if different from patient): _____
Phone: _____

LIFESTYLE AND DIAGNOSTIC INFORMATION

(checkmark if your answer is "yes")

Do you…

❑ own a pair of prescription glasses? If yes, how old are your glasses? _____
❑ have more than one pair of prescription eyewear?
❑ think you might benefit from thinner, lighter lenses?
❑ have prescription sunglasses?
❑ have interest in trying out a new contact lens design?
❑ spend time on a device? If so, how many monitors do you use? _____ Multiple devices used? _____
❑ spend time outdoors? How many hrs/week? _____
❑ participate in sports? Which ones? _____
❑ have children or other family members in need of eyecare?
❑ have an east/west commute?
❑ struggle with glare from the sun or driving at night?
❑ have difficulty reading, lose your place during reading, or have to re-read the same line over and over?
Are you left or right hand dominant? _____

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 BE SURE TO FILL OUT BOTH SIDES OF THIS FORM

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

PATIENT MEDICAL HISTORY

Family Physician _____
Address _____
Phone _____
Date of Last Physical/Check-up _____

CURRENT MEDICATIONS (Rx and Over-the-Counter)
List names of **all** prescription medications, supplements, eye drops, and herbal supplements, including birth control.

_____
_____
_____

If you have a medication list please give it to the Front Desk.

Are you allergic to any medications? ❑ YES ❑ NO
If so, which medications? _____

Have you had any *recent* surgeries? ❑ YES ❑ NO
What surgery? _____
When? _____

SOCIAL HISTORY:
Checkmark any of the following that you use…

❑ *Cigarettes/Tobacco*
If so, how much? ❑ less than a pack/day
❑ about a pack/day
❑ 2 packs/day
❑ more than 2 packs/day
❑ How long have you used tobacco? _____

❑ *Alcohol*
❑ Social only ❑ 1-2 drinks daily ❑ more

❑ *Illegal substances?* What? _____

❑ *None of the above*

Have you been diagnosed/treated for the following:

❑ Allergies
❑ Blood/Lymph
❑ Cancer (type _____)
❑ Bronchitis
❑ Asthma
❑ Endocrine
❑ Fatigue
❑ High Blood Pressure
❑ Skin problems
❑ Muscle/Bone
❑ Psychological
❑ Chronic Sinusitis
❑ *Unusual* weight gain/loss
❑ Seizures
❑ Diabetes: Average blood sugar _____
Last hemoglobin (HbA1c) _____%
❑ Major blood loss
❑ Arthritis
❑ Cholesterol
❑ Digestive
❑ Ears/Nose/Throat
❑ Eczema/Rashes
❑ Fevers
❑ Genitourinary
❑ Kidney
❑ Neurological
❑ Respiratory
❑ Thyroid
❑ Migraines
❑ Sleep apnea

PATIENT EYE HISTORY

Approximate Date of Last Eye Exam _____
By Whom? _____

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

❑ Allergy(ies)
❑ Burning
❑ Corneal Abrasion
❑ Double vision
❑ Eye injury(ies)
❑ Floaters/spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Dryness
❑ Sunlight sensitivity
❑ Trouble seeing at night
❑ Other eye disorders: _____
❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/eye turn
❑ Eye infection(s)
❑ Flashes of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular degeneration
❑ Retinal detachment
❑ Tearing
❑ Uncomfortable glasses

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? _____
Solution(s) used _____
Do you own a pair of glasses? ❑ YES ❑ NO
If yes, how old are your glasses? _____

FAMILY MEDICAL/EYE HISTORY (checkmark all that apply)

Is there a family medical history or any of the following?
(Relationship/who? Mom or dad's 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 ❑_____

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 (**HIPAA**) of 1996, 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 _____ DATE OF BIRTH _____

☐ I authorize the release of information, including my examination, diagnosis, records, and claims information. Access to my medical record and/or Personal Health Information is granted to (please write name[s] below):

☐ Spouse/Significant Other _____

☐ Parent/Child(ren) _____

☐ Other _____

* This Release of Information will remain in effect until terminated by me, in writing.

☐ Information is not to be released to anyone.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____ RELATIONSHIP TO PATIENT _____

Assignment and Release/Signature-on-File (SOF)

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. 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 my insurance company(ies) and their agents for the purpose of obtaining payment for services, determining insurance benefits, or determining the benefits payable for related services.

PATIENT/GUARDIAN 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 an appointment cancellation/no-show policy. If you cancel your appointment with less than 24 hours' notice, do not show up for an appointment, OR consistently reschedule your 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.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____ RELATIONSHIP TO PATIENT _____