

Welcome to Dr. Faye N. Tupa, O.D., P.C.!

We want to welcome you and appreciate that you have chosen us as your family eye care provider. This diagnostic form will help us in evaluating both your vision and total eye and body health. Please take a few moments to complete it.

PERSONAL INFORMATION

Name: Last: _____ First: _____ M.I. _____ Title: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ SS#: _____ Marital Status: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Hobbies/Interests? _____
Medical Insurance: _____ Vision Insurance: _____
Secondary Insurance (if applicable): _____
Race: African American Asian Hispanic Native American White Other _____
Ethnicity: Hispanic Non-Hispanic Native American
Preferred Language: _____

FOR PATIENTS FILING INSURANCE CLAIMS

We work hard to verify medical and vision insurance benefits. There are times that the benefits provided to us by the insurance company are not correct. We are not responsible for incorrect information given to us by the insurance companies such as coverage, co-pays, allowances and any other information they provide. You are responsible for any amount that is not covered or paid for by your insurance company for services or materials that are provided by Dr. Faye N. Tupa, O.D., P.C. Full payment is expected within thirty days of such notice from the date the bill was mailed.

I hereby authorize my insurance benefits be paid directly to the physician and I also authorize the physician to release any information required to process the claim.

Routine vs. Medical Exams

A **routine** exam is when there are no medical problems or diseases that affect a patient's vision. Vision plan insurance is used for this type of visit.

A **medical** exam is when a problem or disease has been identified by the physician or if the patient is experiencing pain, ongoing headaches, dry eyes or any symptom that is associated or indicative of a medical issue. Medical insurances are used for these types of exams.

Please note that a medical exam is necessary for ALL glaucoma and diabetic patients as well as any patient with medical history that directly affects the vision system.

Patient/Guardian Signature

Date

The law requires that Faye N. Tupa, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I was given the opportunity to read or have explained to me Faye N. Tupa, O.D., P.C.'s Notice of Privacy Practice and agree to continue my care with Faye N. Tupa, O.D., P.C. under said terms.

Patient/Guardian Signature

Date

Primary Care Physician (or Clinic): _____ Date of last visit: _____

Reason for last visit: Check-up Physical RX refill Other: _____

Medications (including over the counter)

NKDA Allergies to Medicine: _____

Have you ever had any surgery or been hospitalized? YES NO

If YES, please explain: _____

Females Are you pregnant? YES NO Are you nursing? YES NO

Have you had a recent tetanus shot? YES NO

Do any medical diseases run in your family (blood relatives)? Please indicate who.

ADOPTED

Diabetes YES NO PARENTS SIBLING GRANDPARENT

HBP YES NO PARENTS SIBLING GRANDPARENT

Stroke YES NO PARENTS SIBLING GRANDPARENT

Cancer YES NO PARENTS SIBLING GRANDPARENT

Thyroid YES NO PARENTS SIBLING GRANDPARENT

Do you smoke? Never smoked Former smoker Current smoker

Do you drink alcohol? No Occasionally 1/day 2-3/day 4+/day

Do you use illegal drugs? YES NO

PUPIL DILATION

We believe dilation is an important part of your exam, but we also understand and respect your desire to make informed decisions about your own healthcare. Sometimes you may need an exam, but dilation might not fit into your plans. We understand. At your visit you may choose not to be dilated.

The most important thing is that our patients understand the benefits and risks of not being dilated. Without dilating the pupils your doctor is not able to fully evaluate the health of the back of the eye. Pupil dilation allows your doctor to inspect your entire retina, the optic nerves, macula, and the blood vessels.

Would you like your eyes to be dilated? YES NO IF NEEDED