Dr.'s Enriquez Leppek and Habermehl
4091 Richfield Rd
Flint, MI 48506-2033
(810) 736-0710

FLINT VISION

There are two types of insurance that will help pay for your eye care services and products.

You may have both and our practice accepts both.

1. Vision care plans (such as VSP and Eyemed)
2. Medical Insurance (such as Medicare and Blue Cross/Blue Shield)

- Vision care plans only cover routine vision exams along with eyeglasses and/or contact Lenses, Vision plans only cover and basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have an eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you.
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, copays or non-covered services as allowed by the insurance contract.

I have read and agree with these above policies.

_____ _____

Patient Signature (or guardian of child) Date

Patient Information Form

(Please Print)

Personal Information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Pastor ☐ Prof. SS#_____ Birth Date: ___/___/____

Last Name:_____ First:_____ MI:_____ Gender: _____

Address:_____ City:_____ State:_____

Zip Code:_____ **Home Phone**:_____ ☐ **Cell Phone**:_____ ☐

** (**PLEASE CHECK PREFERRED CONTACT**) ** **Text Cell Phone** ☐

Email Address:_____

Current Employer/Occupation:_____

(Grade if student)

Emergency Contact Name & Phone Number:_____

Relationship to patient:_____

Medical and Visual History:

Primary Care Physician & Phone Number:_____

Preferred Pharmacy:(name, location and phone number) _____

Date of Last Vision Exam:_____

Medications:_____

Medication Allergies:_____

Are you pregnant or nursing?_____

Check any medical conditions that apply to you:

☐ Allergies ☐ Headaches ☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure

Please describe any other medical conditions that may apply:_____

_____

Check any eye conditions that apply to you:

☐Eye Surgery ☐ Glaucoma ☐ Cataracts ☐ Dry Eye ☐ Macular Degeneration ☐ Lazy Eye ☐ Floaters

☐ Light Flashes☐ Eye Turn ☐ Past Eye Injury ☐ None

Immediate Family History:

Check any conditions that apply and indicate the relationship to the patient:

☐Glaucoma_____	☐Heart Disease_____	☐High Blood Pressure_____
☐Diabetes_____	☐Macular Degeneration_____	☐Cancer_____
☐ Cataracts_____	☐ None	

Do you currently smoke : ☐Yes ☐ No Amount:_____ ☐ Daily ☐Weekly ☐ Occasionally

Do you drink alcohol: ☐ Yes ☐ No Amount:_____ ☐ Daily ☐ Weekly ☐ Occasionally

Glasses and Contact Lens History:

Do you currently wear glasses? ☐Yes ☐ No

Do you notice glare at night? ☐ Yes ☐ No ☐ Unsure

Do you wear sunglasses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Are you interested in contacts? ☐ Yes☐ No

Please describe any past problems with contacts:_____

Type of contacts worn: ☐ Dailies ☐ Extended Wear ☐ Rigid Gas Permerable ☐ Bifocal ☐ Colored ☐ Other

Are you interested in Lasik? ☐ Yes ☐ No

Activites and Interests:
Please check all that apply:
☐ Contact Sports ☐ Basketball/Volleyball ☐ Reading ☐Sewing/Crafts ☐ Baseball/Softball ☐ Soccer
☐Other: _____
How many hours per day do you use a computer/tablet? _____

Financial Information:
Payment for service(s) is required at the time of service. Please indicate below how you intend to pay for your professional fees and/or materials not covered by any insurance. We accept the following forms of payment: ☐ Cash or Check ☐ MasterCard/Visa ☐ Discover ☐

How did you hear about us?
__ Newspaper __ Facebook __ Insurance List __ Other: _____
If you learned about us from a referral, please list his/her name so we can thank them:

If you are using insurance vision and/or medical, please complete the following section: Primary Insurance:
Name of insurance _____
Primary insured's name _____
Relationship to patient _____
Policy # _____ Group # _____
Primary's DOB _____/_____/_____
Primary's SS #_____

Secondary Insurance:
Name of insurance _____
Primary insured's name _____
Relationship to patient _____
Policy # _____ Group # _____
Primary's DOB _____/_____/_____
Primary's SS #_____
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In compliance with HIPAA and Flint Vision Optical Care policy, we may not release any medical or payment information to any persons without written consent of the patient. To allow access to all patient records and information please indicate here (none or full name/relationship):_____
Patient, Parent or Guardian Signature:_____
Date: _____/_____/_____

Please sign below stating that everything is completed to the best of your knowledge and acknowledging you have read and fully understand the HIPAA form. You may receive a copy of HIPAA upon request.
Patient Name:_____
(Please Print)
Patient Signature:_____ Date:_____/_____/_____
(Parent or Gaurdian if patient is a minor).