

## PATIENT INFORMATION

Please print and complete *all* information

Patient Name: \_\_\_\_\_  
                                First  Middle  Last

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Single Married Divorced Widow (circle one) E-mail address \_\_\_\_\_

School or Employer: \_\_\_\_\_

Position: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Parent's or Spouse's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/spouse Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Person responsible for payment: \_\_\_\_\_

Name of person to contact in an emergency situation (someone not in your home):

\_\_\_\_\_ Phone Number: \_\_\_\_\_

***Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay all copays, deductibles, co-insurance, or any other balance not paid for by your insurance.***

I have read and understand the above statement:

X \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST ALONG WITH YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION SO THAT WE MAKE A COPY OF THEM.**

**THANK YOU**



**Wagner Family Eyecare**  
 3285 State Route 257  
 PO Box 307  
 Seneca, PA 16346  
 www.wagnerfamilyeyecare.com

**David A. Wagner, OD**  
**Kelly L. Seibert, OD**  
 Phone: 814 677-6636  
 Fax: 814 677-9562

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of Patient

\_\_\_\_\_  
 Date of Birth

**Please answer all of the following questions about your medical status and history:**

1. Have you ever been treated for any medical condition (diabetes, high blood pressure, arthritis, etc.)?  
 Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_
2. Have you ever had any eye disease (glaucoma, cataract, wandering or lazy eye, retinal detachment, etc.)?  
 Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_
3. Have you ever had **any** surgery?  
 Yes \_\_\_ No \_\_\_ If yes, please provide date and reason \_\_\_\_\_
  
4. Have you ever been hospitalized?  
 Yes \_\_\_ No \_\_\_ If yes, please provide date and reason \_\_\_\_\_
  
5. Do you take any medications or vitamins?  
 Yes \_\_\_ No \_\_\_ If yes, please list: \_\_\_\_\_
6. Do you take any eye medications?  
 Yes \_\_\_ No \_\_\_ If yes, please list: \_\_\_\_\_
7. Do you have any food or drug allergies?  
 Yes \_\_\_ No \_\_\_ If yes, please list: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

**YES NO PLEASE EXPLAIN**

- Do you currently have any of the following conditions?
- |   |       |       |       |
|---|-------|-------|-------|
| Chronic fever, unexpected weight loss/gain, fatigue                       | _____ | _____ | _____ |
| Ear/nose/throat problems (hearing loss, sinus problem, sore throat)       | _____ | _____ | _____ |
| Heart problems (chest pain, irregular heart beat, etc.)                   | _____ | _____ | _____ |
| Respiratory problems (shortness of breath, wheezing, coughing)            | _____ | _____ | _____ |
| Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting) | _____ | _____ | _____ |
| Urinary problems (pain or discomfort, blood in urine)                     | _____ | _____ | _____ |
| Skin problems (rashes, excessive dryness)                                 | _____ | _____ | _____ |
| Musculoskeletal problems (muscle aches, joint pain, swollen joints)       | _____ | _____ | _____ |
| Neurological problems (numbness, weakness, headaches, paralysis)          | _____ | _____ | _____ |
| Psychiatric problems (depression, anxiety, panic attacks)                 | _____ | _____ | _____ |

8. Do any **medical** or **eye diseases** run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_
  
9. Do you smoke? If yes, how much? \_\_\_\_\_ Do you drink alcohol? If yes, how much? \_\_\_\_\_  
 Do you use any illicit or illegal drugs? If yes, what and how often? \_\_\_\_\_
10. If employed, how many hours per week do you work? \_\_\_\_\_
11. Does your employment contribute to any stress in your life? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date



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**Patient Information**

**Guarantor**

*Person who carries the insurance*

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

I request that payment of authorized benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any service furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient or Parent Signature

\_\_\_\_\_  
Date

**Supplemental / Secondary Insurance Info.**

I request that payment of authorized Supplemental Insurance benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to (ins. name) \_\_\_\_\_ any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient or Parent Signature

\_\_\_\_\_  
Date



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**Complaints:**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or Email shown above. If you prefer, you can discuss your complaint in person or by phone.

**Changes to This Notice:**

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: January 1, 2014.

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I was offered a copy of Wagner Family Eyecare, PC, Notice of Privacy Practices.

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Signature \_\_\_\_\_



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### Return Policy for Eyeglasses

**All sales of prescription and non-prescription eyeglasses and sunglasses are final.** If, however, there are any discrepancies between the doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included once at no charge within 90 days of purchase date. Any prescription changes after 90 days, 50% will be taken off of the new lens price. All orders require a minimum 50% deposit. Adjustments for glasses and minor repairs are provided free of charge for glasses purchased from Wagner Family Eyecare PC.

#### **Frame/Lens Warranty**

Most of our eyeglass frames are under manufacturer warranty covering any manufacturing defects for up to one year from the date of purchase. Select frame companies offer longer warranties. This does not include mishandling or abuse. This is a one-time replacement warranty.

Most prescription lenses will have a 1 year scratch coat warranty. This does not imply that the lenses will not scratch. They are scratch resistant not scratch proof. Scratches in the lenses that can be felt with a fingernail or chips caused by abuse are not covered.

Should you need a frame and/or lens replacement that is not covered under the manufacturer's warranty as specified above, Wagner Family Eyecare PC will extend a 50% discount off the retail price to replace a frame and 50% discount off the retail price to replace lenses up to one year of purchase date.

If you add Anti-reflective coating, transition, or UV coating ETC. and decide it is not right for you, the lenses can be remade once within 90 days of the purchase date at no additional cost. However, the original cost(s) of these coating and enhancements are non-refundable.

#### **Non-adapt policy**

If you are fit into a progressive (no line bifocal) and cannot properly adapt to this type of lens, Wagner Family Eyecare PC will make your lenses into either a single vision or lined bifocal at no additional cost to you within 90 days. The new lenses should be put into the original frame purchased. If you choose to change frames, new lenses will be 50% off original cost and you will be responsible for the cost of the price difference in the frame. Wagner Family Eyecare PC will not refund the original cost of the progressive lens.

**I have read, understood, and shall abide by all aspects of the policies explained to me above.**

**Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



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Many of our patients have medical and vision insurance and we want you to understand the difference between the two. This is important because they differ in what they cover, pay, etc.

Vision coverage is designed to determine a prescription for glasses or contacts, and is not equipped to deal with complex medical or eye conditions and/or diseases, and does not include a detailed retinal exam. Therefore, the fee for this service is usually lower.

When a medical condition or diagnosis is present (such as hypertension, diabetes, or eye disease), medical insurers require us to file with your medical insurance. Any copays or deductibles you have for medical specialists or testing will then apply. There are several levels of medical exams with varying fees. Some components of medical exams may not be covered by your insurance; therefore you would be responsible for those fees. Medical fees are usually higher than visual fees. If you do not have medical insurance but require a medical exam, please realize you will pay a higher fee than the normal well-visit exam.

If you have insurance, we HAVE to be able to verify coverage before you are seen. You are responsible for presenting your most recent insurance cards. The only exception to this is an ocular emergency.

Our office does not make these rules. They are defined by the insurance companies. Often we will not know which type of exam you require until we start our testing. We try to take as many insurances as possible, but if we do not take yours, we will give you a printed receipt to file with your insurance company.

By signing below, you state that you understand the above and assign all benefits to us. Whether or not you have insurance, you also understand that you are responsible for your charges.

If you fail to pay your bill in a timely manner, 5% per month finance charges will apply after a 90 day grace period. Should it be necessary to send this account to a collection agency, you will be responsible for all collection fees which may be up to 35% additional fees.

**All fees, insurance copays and contact fitting fees (that insurance may not cover) are due at the completion of your exam.**

**Also, since eye exams are a service, NO refunds are available.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Relationship to Patient