

Last Name _____ First Name _____ Birth Date ____ / ____ / ____

Patient SS# (required) _____ Employer & Occupation _____

How did you hear about us? _____ Reason for today's exam _____

Are you interested in contacts? _____ Do you currently wear contacts? Y N

Medical Primary Insured's Name : _____ DOB ____ / ____ / ____ SS# _____

Relationship to patient: (circle) *Self Spouse Dependent*

Vision Primary Insured's Name (if different than medical) : _____ DOB ____ / ____ / ____

SS# _____ Relationship to patient: (circle) *Self Spouse Dependent*

I have read and understood the HIPPA privacy policy provided Signature _____

Once a year, the Optomap retinal imaging is recommended to evaluate the full health of your eyes. This provides a fast, easy and permanent record to compare and track your potential eye problems. Without viewing the interior eye, serious eye diseases that can lead to blindness and death will be missed.

Yes I would like the Doctor to check the full health of my eyes using the Optomap (there is a small fee of \$39 for this imaging)

No I have elected not to have retinal imaging today and will dilate. (Side effects including light sensitivity and blurred vision typically lasting for 6 hours but in some individuals may last for days.)

No I refuse both dilation and retinal imaging. THIS OPTION IS NOT A COMPLETE EXAM I understand the serious health and vision risks of an incomplete eye exam.

Patient Signature

Date

Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services necessary for the maintenance of good health that may not be covered by your insurance company contract. As we progress with your treatment we will discuss any services we feel may not be covered although we will not always know for certain how your insurance company will process your claim. You will be expected to pay for any non-covered services. Please note that verifying insurance coverage is your responsibility. If you have a question about your coverage, please contact your insurance provider directly. If we file a claim and a service or procedure is denied, you will be billed directly for all costs associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any uncovered services if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have is separate from and not included in these fees. I also understand that an additional \$30 collections fee will be charged to any account that is turned over to the collections agency after for non-payment of services after 60 days.

Patient Signature

Date

Please review the following and check those that apply. List medications you take for each condition.

Medical	Yourself	List medications	Relative-list relationship
Diabetes			
High Blood Pressure			
Cholesterol			
Heart Disease			
Thyroid			
Arthritis			
Cancer (list type)			
Respiratory			
Behavioral/Psychiatric			
HIV/AIDS			
Herpes			
Shingles			
Allergies to Medication			
Other conditions (list type)			
Current or Former Smoker			

Ocular	Yourself	Please list any eye drops used	Relative-list relationship
Glaucoma			
Dry Eye			
Retinal Detachment			
Macular Degeneration			
Eye Surgery			
Eye Injury			
Eye Allergies			
Prior Eye Infections			
Other (list condition)			

Medical Follow Up: _____ CL F/U: _____ Medical / Vision

Refraction Non-billable photos CL Fitting Special Procedure : _____