Welcome Back to The Eye Doctor

Returning Patient Information

Reason for today's visit? □ Glasses □ Contacts □ Medical If medical, specify: _____

□ Mr. □ Mrs. □ Ms. □ Dr. Name _____ Nickname _____ Date_____

Street _____ City _____ State_____ Zip_____

Date of Birth____/____/_____ Age _____ Sex M F Social Security _____-_____-_____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred method of communication: □ Home □ Work or □ Cell
Please describe your occupation_____
Computer use: □ Y □ N Hobbies & Sports_____

Health History

Family Dr. _____ Family Dr. Phone Number _____ Last Physical Exam _____

Do you use tobacco products? Y/N Do you drink alcohol? Y/N For Women: Pregnant/Nursing? Y/N

If Diabetic:
Date Diagnosed: ____/_____/_____ Last Blood Sugar: _____mg/dl Last Hemoglobin A1C: _____%

Please list ALL medications:	What medications are you allergic to:	Please list any eye surgeries:

Insurance Information

Vision Insurance _____
Subscriber's Name_____
Subscriber's DOB ____/_____/_____
Patient's Relationship to Insured:
□ self □ child □ spouse
Subscriber's ID _____

Medical Insurance (Primary) _____
Subscriber's Name_____
Subscriber's DOB ____/_____/_____
Patient's Relationship to Insured:
□ self □ child □ spouse
Subscriber's ID _____

Consent for Dilated Retinal Examination

The doctors at The Eye Doctor LLC strongly recommend a dilated retinal examination, which allows the doctor to view your internal retinal health. The retina is the light sensitive tissue lining the inside of your eyes.

We are concerned about retinal problems including macular degeneration, glaucoma, retinal holes or detachments, tumors and systemic diseases such as diabetes, stroke and high blood pressure. These conditions can lead to serious health problems including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.

Dilation involves the use of eye drops to dilate your pupils, allowing the doctor to view inside your eye. These drops may cause blurred vision and light sensitivity for several hours.

Your insurance may cover retinal dilation, so be sure to let us know about your insurance coverage. Because The Eye Doctor advises ALL of our patients to have this important dilated examination, we will perform the dilated retinal examination as an enhanced service for an additional fee of only **$35.00** for both eyes at your annual eye examination.

YES: By signing below I have elected to have my eyes dilated.

Patient Signature _____ Date _____

NO: By signing below I have elected NOT to have dilation performed today against the recommendation of my Doctor.

Patient Signature _____ Date _____

Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered. After 45 days, balances are considered delinquent, and are subject to a fee of **$15** for every statement we send you. Checks that fail to clear are subject to a **$50** fee. We MUST be notified at least 24 hours in advance should you need to cancel/reschedule your appointment or you will be charged a fee of **$40**. Failure to show up to your scheduled appointment will also result in a fee of **$40**. You will be personally responsible for this charge because it cannot be billed to your insurance company.
_____ ***(Initial in shaded area)***

Please let us know your **vision** and **medical** insurance **prior** to your visit and if you wish to use it. Although we participate in many insurances, this is not a guarantee of benefits and it is your responsibility to know your insurance benefits and eligibility. Please provide us with your current, valid insurance card(s) as well as any complete referrals or forms required by your insurance. Medical conditions may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. In such cases, it is important that you communicate with our office about your medical insurance and any referrals you may need. If you notify us of your desire to use insurance *after* services are rendered, you may request an itemized receipt to submit to your insurance company for reimbursement directly from your plan. However, be aware that your insurance company may only send you a partial reimbursement or nothing at all, depending on your insurance company's policies, contractual rates and procedures. It is every patient's responsibility to know their insurance plan, referrals and/or certification procedures needed for their insurance plan.
_____ ***(Initial in shaded area)***

Contact lens services incur additional fees that your insurance may not cover. The initial contact lens fitting period includes 2 follow-up visits within 60 days of the initial fitting or otherwise as indicated by your insurance. Should the fitting period elapse before finalizing your contact lens prescription, a new fitting fee applies.
_____ ***(Initial in shaded area)***

The **Health Insurance Portability & Accountability Act of 1996 ("HIPAA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a **"Notice of Privacy Practices Policy"**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Eye Doctor, Notice of Privacy Practices.

Date_____ Patient Name_____ Signature_____

The Doctors or staff may discuss my situation or condition with the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____