Patient's Name:_____ Date of Birth: _____/_____/_____

Social Security Number:_____ Email:_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Tel:_____

Emergency Contact:_____ Tel:_____

Insurance Information: (Patient must provide both **MEDICAL AND VISION** insurance cards.)

Our office participates with various vision and medical insurance plans. Most vision plans are only intended for routine eye exams. Please note that eye exams that are intended for and/or result in a medical diagnosis may need to be filed with your medical insurance. The type of insurance plan needed for the exam can only be determined at the conclusion of the exam, therefore our staff must collect information regarding both vision and medical plans before the exam. Our office makes every effort to verify the amount owed by the patient at the day of the exam. However, the exact amount of patient's responsibility can only be determined after the claim has been filed. If this amount differs from the amount charged on the exam date, the patient will be sent a bill for the remaining balance or a refund in case of overpayment. Patient is also responsible for payment of services denied or otherwise not paid by his/her insurance company in a timely manner. If there is no insurance, all professional fees are due on the day of exam. By signing at the bottom of this page you agree to these terms and you authorize payment of medical benefits to our providers for the services they rendered.

	PRIMARY MEDICAL INSURANCE	PRIMARY VISION PLAN
INSURANCE COMPANY		
MEMBER ID		
SUBSCRIBER'S NAME		
SUBSCRIBER'S DOB		
RELATIONSHIP TO PATIENT		

Please list any additional medical/vision insurance:_____

Correspondence Consents:

Can we contact you via text message? Circle **YES** or **NO** What about email? Circle: **YES** or **NO**

Can we leave you detailed voicemails with regards to your health information? Circle: **YES** or **NO**

List any individuals whom we may share your health information with and include their phone number:

_____

Visual Field Screening Consent:

Automated visual field screening is a technologically advanced method recommended by our doctors to assess both central and peripheral field of vision for major defects. It is specially useful in detecting certain types/stages of glaucoma, brain tumors, aneurysms, strokes, and other ocular/neurological disorders. It may also help our doctors to determine causes of unexplained headaches. The test is non-invasive and takes approximately 1 minute per eye.

The out of pocket cost for the test is $25.

Do you want to have the test performed? Circle: **YES** or **NO**

_____ _____/_____/_____

Signature of Patient (Parent/Guardian if patient is under 18) Date

Patient's Name:_____ Date of Birth: _____/_____/_____

Please list all previous eye surgery, trauma, and diagnosis with date: (Or mark: ☐None)

_____

_____

When was your last eye exam?_____/_____/_____ Where?_____

Have you ever worn contact lenses? Circle: **YES** or **NO** If YES, circle: **SOFT** or **RGP** or **OTHER**

Who is your primary care physician?_____

Please list all medications that you take, including eye drops and over-the-counters: (Or mark: ☐None)

_____

_____

Please list all medications that you are allergic to: (Or mark: ☐None)

_____

_____

Please mark all conditions and social habits that apply to you:

Eyes:	☐None	☐Decreased vision	☐Seeing Floaters	☐Seeing Flashes	☐Double vision
General:	☐None	☐Pregnancy	☐Breastfeeding	☐Cancer	
Genitourinary:	☐None	☐Kidney Disease	☐Prostate Problem		
Gastrointestinal:	☐None	☐Liver Disease	☐Colitis		
Psychiatric:	☐None	☐Anxiety	☐Panic Attacks		
Endocrine:	☐None	☐Thyroid Disorder	☐History of Diabetes		
ENT:	☐None	☐Sinus Problem	☐Hearing Loss		
Allergic, immunologic:	☐None	☐Seasonal Allergy	☐Lupus		
Integumentary:	☐None	☐Psoriasis	☐Dermatitis		
Cardiovascular:	☐None	☐Heart Disease	☐History of High Blood Pressure		
Musculoskeletal:	☐None	☐Arthritis	☐Multiple Sclerosis	☐Disabled	
Respiratory:	☐None	☐Asthma	☐COPD	☐Bronchitis	
Hematologic, lymphatic:	☐None	☐High cholesterol	☐Anemia	☐HIV	
Neurological:	☐None	☐Headaches	☐Stroke	☐Dizziness	
Social:	☐Current Smoker	☐Former Smoker	☐Social Drinking	☐Daily drinking	

Do any of your family members suffer from any of the following conditions? (Circle all that apply)

Cataracts Glaucoma Macular degeneration Hypertension Diabetes Cancer Heart disease

What is your occupation?_____ What is your Gender?_____

What is your Race?_____ What is your Ethnicity?_____

_____ _____/_____/_____

Signature of Patient (Parent/Guardian if patient is under 18) Date

Patient's Name:_____ Date of Birth: _____/_____/_____

Contact Lens Fitting Consent
(Skip this page if the patient does not want to be prescribed contact lenses.)

I understand that contact lenses are medical devices and prescribing them requires a higher level of professional judgment and liability than a standard comprehensive exam, therefore there is an additional fee to have a contact lens prescription which may or may not be covered by my (the patient's) insurance plan. I agree to not wear contact lenses unless I am properly trained on proper insertion, removal, and care of them by an eye care professional. I understand that the contact lens evaluation fee covers up to three follow visits as needed within 90 days of the initial fitting. I understand that contact lens prescription can not be finalized until the appropriate trial period and necessary follow ups are completed. I understand that wearing contact lenses comes with possible complications such as inflammation and infections which have the potential of causing temporary or even permanent vision loss. I understand that such risks are significantly higher for extended wear of contact lenses, therefore contact lenses must be taken out and properly cleaned and stored before sleeping. Daily disposable contact lenses must be disposed of after one day of wear. I understand that I must inform the doctor if I plan to sleep in contact lenses so I can be fitted in the right type of contact lens. Other factors that increase the risk of complications included improper care of contact lenses, not replacing disposable contact lenses based on the recommended schedule, and swimming/showering in contact lenses. I understand that if I experience symptoms such as redness, irritation, eye pain, burning, reduced vision, and/or other ocular complications, I must discontinue contact lens wear right away and follow up with my eye doctor or the emergency room as soon as possible. By signing below I agree to these terms and authorize the doctor to evaluate and fit me (the patient) for contact lenses.

_____ _____/_____/_____
Signature of Patient (Parent/Guardian if patient is under 18) Date