Welcome Back To HAWK EYE CENTER

Patient Name: ______________________ Cell Ph #: ______________________ Email: ______________________

Please let us know if there have been any changes to your demographics such as address, name, phone #, etc.

We are now making greater use of email and texting to communicate with our patients. All patient information is kept strictly confidential. Your email and cell ph # is **NEVER** shared. **May we communicate with you via email and texting: □ Yes □ No**

Insurance information

Vision Insurance ______________________ Medical Insurance ______________________ Med. Ins. ID #: ______________________

Insured's Name: ______________________ Relationship to insured: ______________________ Med. Ins. Group # ______________________

Insured's Employer: ______________________ Insured's Birth date ______________________ Insured's SSN: ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance plan(s) stated above and assign directly to Hawk Eye Center all exam and material insurance benefits, if any, otherwise payable to me for materials provided and services rendered. I understand that any quotes provided by Hawk Eye Center are estimates and may not reflect the exact amount that I will be responsible for. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorized Hawk Eye Center and the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Responsible Party Signature **Relationship**

Dilation (Pupil Enlargement) and Computerized Screening Tests - Please Read Carefully

VISUAL FIELDS TEST – A highly advanced computerized instrument that provides a more thorough visual field screening. This instrument checks for loss of sight in both the central and peripheral areas. Visual field testing can assist us in early detection of glaucoma, retinal problems, and some neurological diseases such as brain tumors and optic nerve disease. It also enables us to better diagnose causes of headaches. **There is an additional fee of $20.00 for this test. Your insurance does not cover this service.**

- □ Yes, I would like the visual fields test
- □ No, I understand the importance of the Visual Field Testing, but I decline to have it performed at this time.
- □ I would like to discuss this with the Doctor.

OPTOMAP RETINAL SCAN – Optomap is an ultra-widefield scan of your retina (the back of the eye), which will help us document, review, and compare your retina over time. We will use the Optomap scan to document a baseline image for our charts, screen for eye diseases and improve our ability to view your internal retinal health at a high resolution. We are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, many symptoms of systemic diseases such as diabetes and the effects of high blood pressure can be detected with the Optomap Retinal Scan. The test is fast, painless and may not require dilation. **There is an additional fee of $39.00 for this test. Your insurance does not cover this service.**

- □ Yes, I agree to have my retinal health evaluated with the Optomap Retinal Scan.
- □ No, I do not wish to have the Optomap Retinal Scan.
- □ I would like to discuss this with the Doctor.

DILATION allows the doctor to thoroughly examine the inside of the eye for diseases such as cataracts, glaucoma, retinal diseases, ocular tumors, and diabetic retinopathy. This procedure is highly recommended for all patients especially those who have not had their eyes dilated in the past 2 years, patients with high prescription, children under 10, and patients over 40 years old. The side effects, which includes blurred near vision, and sensitivity to light will last about 3-4 hours.

- □ Yes, I would like dilation
- □ No, I do not want dilation and assume the responsibility of having an eye examination without dilation.

Signature/Parent's Signature: ______________________________ Date: ______________________