# Five Points Eyecare Consent Form

## Patient Information

Last Name:_____ First Name:_____MI:_____

Email: _____

SS# _____ Gender M / F Date of Birth:_____Age:_____

Address:_____ City: _____

State:_____Zip_____ Home Phone: _____

Cell Phone:_____ Work Phone: _____

Occupation:_____ Employer: _____

Vision Insurance Plan:_____ Medical Insurance Plan: _____

Responsible for the account:_____DOB:_____
(if different than the above)

## Practice Policy / HIPPA (Health Insurance Portability and Accountability Act of 1996)

**If you are using vision/medical insurance coverage for today's visit:** I hereby authorize Five Points Eyecare to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that any such coverage is denied I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. A valid insurance card must be presented at the time of service. Please acknowledge that you have read/agreed to this statement by signing below.

**Contact Lens Evaluation Fees:** Wearing contact lenses is considered an elective form of vision correction, therefore the Contact Lens Diagnostic Evaluation is not covered and is in addition to your exam fee and you are responsible for this charge. Some insurance plans do allow a certain reimbursement for the contact lenses in lieu of glasses. I understand that there is an additional fee associated with the diagnostic evaluation of contact lenses whether I am a current contact lens wearer or new to contact lenses. This fee is due at the time of service.

*CONTACT LENS PRESCRIPTIONS EXPIRE AFTER ONE YEAR.*

**$85** **New** Contact Lens Diagnostic Evaluation and Fitting Fee

**$55** **Established** Contact Lens Diagnostic Evaluation, Fitting and Update Fee

**Yes** **No** Do you wish to be fit for contact lenses today?

***Note: The Contact Lens Evaluation Fee is not covered by Medicaid.***

I (name printed above) have been presented with **Notice of Privacy Policy (HIPPA)** of Five Points Optical Center and have the right to request a copy of such policy for my records.

**Patient Signature:**_____**Date:**_____
(parent/guardian if minor)

# Five Points Eyecare
## Patient Medical and Ocular History Form

**Reason for today's visit**: (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Blurred vision | ☐ | Failed vision screening | ☐ | Diabetic eye exam | ☐ |
| New glasses | ☐ | Dry eyes | ☐ | LASIK | ☐ |
| Contact lenses | ☐ | Cataracts | ☐ | Other:_____ | |
| Ocular foreign body | ☐ | Eye infections/red eyes | ☐ | _____ | |

Please describe any concerns you have regarding your eyes, vision, or ocular health:

_____
_____
_____
_____

Date of Last Eye Exam:_____Doctor/Location:_____

Please list all **medications** you currently take and reason (for example: Lipitor for cholesterol):

_____ _____
_____ _____
_____ _____
_____ _____

**Do you use...** (additional information/details)

| | | |
|---|---|---|
| Eyeglasses? | Y / N | _____ |
| Contact lenses? | Y / N | if yes, what kind_____ |
| Drug Store readers? | Y / N | _____ |
| Any Eye drops? | Y / N | _____ |

**Are you ...**

| | |
|---|---|
| Allergic to any Medications? | Y / N _____ |
| Pregnant or Nursing? | Y / N if yes, due date _____ |

## Review of Systems

| Ocular | Self | Family | Relation/Comment | Medical | Self | Family | Relation/Comment |
|---|---|---|---|---|---|---|---|
| Lazy eye | ☐ | ☐ | _____ | High blood pressure | ☐ | ☐ | _____ |
| Color blind | ☐ | ☐ | _____ | Cholesterol | ☐ | ☐ | _____ |
| Eyestrain | ☐ | ☐ | _____ | Diabetes | ☐ | ☐ | _____ |
| Dry eyes | ☐ | ☐ | _____ | Thyroid | ☐ | ☐ | _____ |
| Floaters/spots | ☐ | ☐ | _____ | Arthritis | ☐ | ☐ | _____ |
| Retinal detachment | ☐ | ☐ | _____ | Cardiovascular | ☐ | ☐ | _____ |
| Blindness | ☐ | ☐ | _____ | Gastrointestinal | ☐ | ☐ | _____ |
| Cataracts | ☐ | ☐ | _____ | Respiratory | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ | Cancer | ☐ | ☐ | _____ |
| Eye injury | ☐ | ☐ | _____ | Headache | ☐ | ☐ | _____ |
| Macular degeneration | ☐ | ☐ | _____ | Migraine | ☐ | ☐ | _____ |
| Corneal degeneration | ☐ | ☐ | _____ | Stroke | ☐ | ☐ | _____ |
| Laser eye treatment | ☐ | ☐ | _____ | Ear/Nose/Throat | ☐ | ☐ | _____ |
| Eye infections | ☐ | ☐ | _____ | Neurological | ☐ | ☐ | _____ |
| Eye surgery | ☐ | ☐ | _____ | Psychological | ☐ | ☐ | _____ |
| Head trauma | ☐ | ☐ | _____ | | | | |

**Patient Name** (print)**:**_____

**Patient Signature:**_____**Date:**_____
(parent/guardian if minor)