



**WILDWOOD EYECARE**

1545 Powers Ferry Rd., Suite 240, Marietta, GA 30067  
Phone: 770-952-6412 Fax: 678-369-7212

**PATIENT INFORMATION & HISTORY**

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_

Please circle: Male / Female Married / Single Occupation \_\_\_\_\_ # Computer hours/day \_\_\_\_\_

Employer \_\_\_\_\_ Employment Status: Full-time / Part-time / Self-employed / Retired / Full-time Student

Vision Insurance \_\_\_\_\_ Medical Insurance \_\_\_\_\_

Primary Insured Member: Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN # \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Pharmacy \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_

Previous Eye Dr. \_\_\_\_\_ Last Eye Exam \_\_\_\_\_ How did you hear about us? Insurance/Friend/Other \_\_\_\_\_

List of Family Members At Practice: \_\_\_\_\_

Reason for visit: Glasses / Contact Lenses / Eye Infection / Eye Injury / Eye Health Exam / Referral / Other \_\_\_\_\_

Do you have any known allergies (medical or environmental)?  No  Yes \_\_\_\_\_

Are you taking any medications?  No  Yes (Please List) \_\_\_\_\_

**Please check any of the following that apply to yourself:**

- |                            |                       |                                             |
|----------------------------|-----------------------|---------------------------------------------|
| Amblyopia / Lazy Eye _____ | Retinal Disease _____ | Cancer _____ what type? _____               |
| Cataracts _____            | HIV Positive _____    | Diabetes Type I _____                       |
| Glaucoma _____             | Anemia _____          | Diabetes Type II _____                      |
| Macular Degeneration _____ | Arthritis _____       | Heart Disease _____                         |
| High Blood Pressure _____  | Kidney Disease _____  | High Cholesterol _____                      |
| Multiple Sclerosis _____   | Migraines _____       | Respiratory Problems _____ what type? _____ |
| Other _____                |                       |                                             |

Have you had any eye injuries or eye surgeries? \_\_\_\_\_ if so, please explain \_\_\_\_\_

**Please check if any of your family members have the following:**

- |                        |                            |
|------------------------|----------------------------|
| Cancer _____           | Hypertension _____         |
| Diabetes Type I _____  | Macular Degeneration _____ |
| Diabetes Type II _____ | Glaucoma _____             |

Do you wear glasses? No / Yes How old are the present glasses? \_\_\_\_\_ What type? Single vision / Bifocal / Trifocal / Progressive / Readers

Do you wear contact lenses? No / Yes How old are your current contacts? \_\_\_\_\_ How often do you dispose your contacts? \_\_\_\_\_

What brand of contacts do you wear? \_\_\_\_\_ Do you sleep in them? No / Yes How many nights a week? \_\_\_\_\_

What solutions do you use? \_\_\_\_\_ Are you experiencing any problems with contacts? Dryness / Discomfort / Redness / Blurred vision



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**Social History:**

Do you currently smoke or use chewing tobacco? No / Yes

**You May Opt Out Of Completing The Next 3 Questions:**

**Preferred Language (Select One):**  English  Spanish  Other: \_\_\_\_\_  Opt Out

**Race: (select One):**  American Indian or Alaska Native  Asian  African American  Hispanic  
 Native Hawaiian  Other Pacific Islander  Caucasian  Opt Out

**Ethnicity (Select One):**  Hispanic or Latino  Native Hawaiian  Other Pacific Islander  Not Hispanic/Latino  Opt Out

**DILATION**

Evaluating the health of the back of the eye each year is a very important part of a comprehensive eye exam. We offer two different forms of this: Dilation Drops and Optos Retinal Imaging.

**Dilation Drops:** Drops are put in the eyes to enlarge the pupil to allow for a view into the back of the eye.

**Optos Retinal Imaging:** A quick and efficient way of monitoring your eye health without using drops. The Optos also allows the doctors to keep a digital photo of your eyes each year and may be used as a comparison in the future. The cost for this service is **\$35.00** and not covered by any insurance.

\_\_\_\_\_ I opt to have the Dilation Drops

\_\_\_\_\_ I opt to have the Optos Retinal Imaging today for an **additional \$35.00 charge.**

**STATEMENT OF FINANCIAL POLICY**

As a service to you, this office offers several means of payment for the services and materials which you may require. It is customary to pay the Professional fees at the time of the examination, and to pay for any required materials (spectacles, contact lenses, special visual aids) and /or follow-up care by paying **50% on ordering and the balance on delivery.**

**\*Eyeglass lenses are a custom prescription item, there are NO refunds for eyewear cancelled after lab work has started.**

You are responsible for any co-pays, co-insurances, deductibles and other non-covered services or materials the day services are rendered. If you are being seen for any ongoing medical condition, co pays are due at each and every visit. Our office accepts cash, personal checks, debit cards, MasterCard, Visa, Discover and American Express.

Vision plans only cover routine vision wellness exams, eyeglasses and contact lenses. Medical eye exams (the diagnosis and treatment of eye health problems) and additional procedures (i.e. fundus photos, visual fields, OCTs) are billed to medical insurance.

Please note that there will be a **\$25 charge for any returned checks.**

**If we are not informed of insurance benefits before services are rendered, we will not be able to file your claim. Loss of benefits may result.**

**INSURANCE AUTHORIZATION**

- I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered.
- I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services and **I agree to be responsible for payment of all services rendered to me or my dependents.**
- I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health care practitioners according to the HIPPA Privacy Laws.

**I certify that I have updated and reviewed my health history, personal contact information and insurance information.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_