DEMOGRAPHICS:

First Name:_____ Last Name: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP) DOB _____ / _____ / _____

CONTACT INFORMATION:

PLEASE CHECK PREFERRED

❑ **CELL** (_____) _____ - _____

❑ **WORK** (_____) _____ - _____

❑ **E-MAIL** _____

Preferred mode of communication? □ **PHONE** □ **TEXT** □ **EMAIL**

INSURANCE INFORMATION: ❑ LIST, _____ ❑ NONE, SELF PAY

REASON FOR VISIT: please print ➜

CONTACT LENS HISTORY: Are you interested in a contact lens exam today? □ **YES** □ **NO**

IF YOU ARE CURRENTLY WEARING CONTACT LENSES PROVIDE THE FOLLOWING INFORMATION **LENS TYPE**: □ **SOFT** □ **HARD** □ **HYBRID** □ **SCLERAL**

LENS NAME: _____ RIGHT POWER: _____

□ **NOT SURE OF BRAND OR POWER** LEFT POWER: _____

REVIEW OF SYSTEMS: PLEASE CIRCLE the condition(s) that apply to you.

❑ ***NO PROBLEMS***	***OTHER***	_____			***GI***	Celiac Disease	Acid Reflux	Colitis	Chron's	Ulcer
BODY	Cancer	Fatigue Syndrome	Developmental Disability		***GU***	Nursing	Prostate Hypertrophy	Herpes	STD	Pregnant
ENT	Sinusitis	Laryngitis	Dry Mouth	Hearing Loss	***MUSC SKELETA***	Osteoarthritis	Muscular Dystrophy	Gout	Ankylosys Spondylitis	Fibromyalgia
NEURO	Cerebral Palsy	Multiple Sclerosis	Stroke/CVA	Epilepsy	Migraines	***SKIN***	Rosacea	Eczema	Cold Sores	Psoriasis	Herpes Zoster
PSYCH	Depression	Bipolar	Attention Deficit	Anxiety Disorder		***ENDO***	Thyroid Dysfunction	Diabetes Type 2	Diabetes Type 1	Hormonal Dysfunction	
CARDIO	Vascular Disease	Stroke/CVA	Hypertension	Heart Failure	Heart Disease	***BLOOD***	Anemia	High Cholesterol	Large Volume Blood Loss		
RESP	Emphysema	Chronic Obstruction	Bronchitis	Sleep Apnea	Asthma	***ALLERGY***	Lupus	Drug Allergies	Sjogren's	Rheumatoid Arthritis	Environmental Allergies

MEDICATIONS: ❑ NONE

Select the therapy that applies, OR list any prescription or non-prescription medications (and strength) that you are currently taking

❑ Acid Reflux Medication	❑ Arthritis Medication	❑ Chemotherapy Agents	❑ Eyedrop - Antibiotic	❑ High Blood Pressure Meds	❑ Topicals (creams/ointments)
❑ Allergy Medication	❑ Asthma Medication	❑ CholesterolMedication	❑Eyedrop - Artificial Tears	❑ Hormone Replacement	❑Vitamins
❑ AntiViral Therapy	❑ Baby Aspirin	❑ Depression Therapy	❑ Eyedrop - Glaucoma	❑ Migraine Therapy	_____
❑ Antibiotic Therapy	❑ Birth Control	❑ Diabetes Medication	❑ Eyedrop - OTC Allergy	❑ Pain Medication	_____
❑ Anxiety Medication	❑ Blood Thinners	❑ Diabetic Insulin	❑ Gout Medication	❑ Thyroid Medication	_____

ALLERGIES: ❑ NONE

List any medication allergies that you may suffer from OR Select the allergy group that applies.

MEDICATION ❑ Sulfa Drugs ❑ Penicillins _____ _____

OTHER ❑ Bee stings ❑ Environmental: Seasonal ❑ Food: Nuts Allergy ❑ LATEX Sensitivity _____ _____

PAST OCULAR HISTORY: Circle any applicable eye conditions to you.

❑ ***NONE***	Strabismus	Retinal Hole	Keratoconus	Amblyopia
Cataracts	Glaucoma Suspect	Eye Patching	Surgery	Retinal Detachment
Glaucoma	Injury	Macular Degeneration	Other: _____	

SOCIAL HISTORY:

Do you drink? □ **NO** □ **YES Amount** _____

Do you smoke? □ **NO** □ **YES Amount** _____

Smoking Status

Never Smoker
Former Smoker
Current: Occasional Smoker
Current: Every Day Smoker

Occupation/ Hobbies _____

FAMILY HISTORY: List immediate family members with these conditions: Father/Mother/Brother/Sister/Son/Daughter

MEDICAL ❑ ***NONE***	Diabetes _____	Cancer _____	High Blood Pressure _____	Other: _____
OCULAR ❑ ***NONE***	Macular Degeneration _____	Glaucoma _____	Amblyopia _____	Other: _____

Please read carefully and initial all office policies on the following page

If needed, verifications of prescriptions will be honored at no charge, only within 45 days of full-exam by appointment only.

ACKNOWLEDGMENT OF OCULAR HEALTH EVALUATION

This office will make every effort to perform a complete retinal evaluation with each comprehensive eye examination. The internal ocular evaluation is an important component of a full evaluation since many eye problems can develop without symptoms. To accomplish a full internal health assessment, our doctors highly recommend that a retinal scan (Optomap) be performed during the preliminary testing and pupil dilation after evaluation of the anterior portion of the eye. The Optomap will allow the doctor to have an ultra-wide view of the retina, establish a baseline and create a digital record of the internal structures of the eyes. Ideally, both Optomap and dilation are performed yearly and in certain cases both are required. I prefer:

❑ **Optomap** The Optomap is a specialized digital scanner that takes images of up to 80% of the internal eye in a panoramic view. The procedure is very simple, painless and it only takes a few seconds to perform with no side effects. This procedure is recommended to be performed yearly and is **not covered by insurance plans.** The cost for the photograph is **$35**.

❑ **Pupil Dilation** This procedure is included as part of your comprehensive eye exam and is essential to establish eye health. It normally **takes 20-25 minutes** after applying eye drops to achieve full pupil dilation. Be advised that you may experience blurred vision when reading or looking-off in the distance and increased light sensitivity for **approximately 4-6 hours**. If today is not a convenient time for you and choose to decline this test today, it can be rescheduled for a more convenient time if necessary but additional charges will apply if not performed within 2 weeks of initial exam.

By initialing this form, **I am acknowledging the importance of the eye health assessment and consent to the Optomap and/or pupil dilation**.

INITIAL _____

CONTACT LENS FITTING POLICY

Contact lenses are medical devices, and State law prohibits dispensing contact lenses without a valid prescription or after one year from the original date of the contact lens evaluation. Disposable trial lenses are for fitting purposes only and will be dispensed at the initial fitting as part of the evaluation if available. Contact lens fittings are priced according to lens type, modality and use. The contact lens fitting prices are:

Soft Standard $60	Soft Astigmatism $80	Soft Monovision $90	Soft Multifocal $90
Hybrid Standard $110	Hybrid Multifocal $120	Hybrid Keratoconus/PS $200	
Gas Permeable Standard $120	Gas Permeable Premium $150	Semi Scleral $375	

A contact lens evaluation will be performed annually to renew the contact lens prescription. The fitting fee includes up to **two follow-up visits within a 45 day** period from the initial evaluation regardless of lens type or modality. We will schedule your follow-up appointment when it is most convenient to you. However, it is the patient's responsibility to make sure that the follow-up visit is completed within the 45 day time-period. If one fails to keep or schedule follow-up visits during the 45 day time-period, additional office visit charges will apply depending on the time period that has elapsed since the initial visit.

Contact lens prescriptions will be released to the patient after the trial or follow-up period is successfully completed. If a patient requires multiple contact lens prescriptions, fittings or evaluations, additional charges will apply. There will be a $20 contact lens fee per visit if more than 2 visits are needed or if its been more than 45 days since the initial fitting. But if it exceeds more than 3 months but less then 6 months, the doctor will need to perform a refraction ($35), before proceeding plus the corresponding fitting charge. If its been more than 6 months since eye examination, we recommend that the complete evaluation and full exam be performed.

One can choose to have a contact lens fitting at a later date for the difference in charge but it must be completed within a 3 month period of the comprehensive eye examination and refraction. Most insurances require that the evaluation be performed at the same time to get benefits. In addition, If you are a new contact lens wearer, a 20 minutes training session is included as part of the evaluation, if additional trainings are needed the charge is $25 for a 20 minute session. Any needed specialty contact lenses modifications must be completed during the first 60 days. If decide not to proceed with specialty lenses such as Hybrids and Scleral a restocking fee of $35 per lens will apply and services are non-refundadble. **Payment for contact lens examinations, as with all other professional fees, is non-refundable.**

INITIAL _____

CONTACT LENS MATERIALS RETURN POLICY

If you are dissatisfied for any reason with the purchase of your contact lens materials, the following policies will apply. Soft contact lens boxes can be returned for credit or refunded within 60 days of purchase as long as the boxes are unopened, undamaged and unmarked (except Frequency Toric's and custom lenses). Gas permeable contact lenses, sclera's, hybrid contact lenses and some soft contacts are made to order and can also be returned within 60 days period but a re-stocking fee is required depending on lens type and design. Regardless of payment type used, an office check will be issued once the credit has been granted from distributor.

INITIAL _____

MEDICAL VISIT POLICY

Most vision insurance plans only cover routine yearly eye examinations but do not cover visits due to medical problems such as red eye, pink eye, corneal problems due to contact lens overwear or foreign bodies. Therefore, since this practice chooses not to file claims for *medical insurance claims*, Medical Visits would be an out of pocket expense. We will provide you with a detailed receipt if you choose to file with your medical insurance provider. Our office visit or medical visits are priced depending on complexity and **start at $50**, if additional **follow-up visits are needed there will start at $25 charge per visit or more** depending on complexity**.**

INITIAL _____

PAYMENT FOR SERVICES AGREEMENT

In most instances medical insurances seldom cover eye exams, contact lens evaluations and contact lens materials. Our office staff will make every effort to verify your benefits but **it is your responsibility to present the adequate insurance or vision discount plan information** at registration for verification before payment is collected.

INSURANCE INFORMATION: ❑ LIST, _____ ❑ NONE, SELF PAY

If the insurance information or any other discount plan is not presented or verified at the moment of registration, it will be my responsibility (or the guardian's if under 18 years of age) to self file the claim with my insurance carrier if possible. Therefore, no other discounts will be honored after services have been provided and payments have been received. My signature indicates that I agree to be financially responsible for my bill, understand the charges and are aware that **payment for professional services is non-refundable**.

INITIAL _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

The privacy act was established by the government to protect all your medical information and requires us to inform you that your medical information is confidential and we can only release it upon your signed request. By initialing you are agreeing that you have been made aware of the Notice of Privacy Practices for Peachtree Eye Associates and a copy of such can be provided upon request**.**

INITIAL _____

ACKNOWLEDGEMENT OF RECEIPT OF RECALL PRACTICES

I authorize to be added to the Lenscrafters recall system and a copy of the policy of Notice of Recall Practices for Peachtree Eye Associates can be provided upon request (reminder calls may be prerecorded or live). Pre-appointed for ____/_____/_____ REMIND VIA ❑ TEXT ❑ EMAIL ❑ PHONE

INITIAL _____

I _____ have read and understand the presented office policies.

PATIENT'S FULL NAME AND/OR LEGAL GUARDIAN

SIGNATURE _____ **TODAY'S DATE** _____ / _____ / _____