DEMOGRAPHICS:

First Name: _____ Last Name: _____

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

CONTACT INFORMATION:

PLEASE CHECK PREFERRED

❑ **HOME** ( ) - ❑ **WORK** ( ) -

❑ **CELL** ( ) - ❑ **E-MAIL** _____

INSURANCE INFORMATION:

❑ **NONE,** SELF PAY

COMPANY _____ **MEMBER #** _____

REASON FOR VISIT: please print →

CONTACT LENS HISTORY:

Are you a current contact lens wearer? If so, what lenses do you use? □ **SOFT** □ **HARD** □ **HYBRID**

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 SKELETAL***	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:

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

❑ ***NONE***	❑ Acid Reflux Medication	❑ Asthma Medication	❑ Depression Therapy	❑ Eyedrop - Glaucoma	❑ Migraine Therapy
	❑ Allergy Medication	❑ Birth Control	❑ Diabetes Medication	❑ Eyedrop - OTC Allergy	❑ Pain Medication
	❑ Antibiotic Therapy	❑ Blood Thinners	❑ Diabetic Insulin	❑ Gout Medication	❑ Prostate Medication
	❑ Anti-viral Therapy	❑ Chemotherapy Agent(s)	❑ Eyedrop - Antibiotic	❑ High Blood Pressure Meds	❑ Topicals (creams/ointments)
	❑ Anxiety Medication	❑ Cholesterol Medication	❑ Eyedrop - Artificial Tears	❑ Hormone Replacement	❑ Vitamins

ALLERGIES:

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

❑ ***NONE***	❑ Sulfa Drugs Allergy	_____	❑ Bee stings	❑ Food: Nuts Allergy
	❑ Penicillins Allergy	_____	❑ Environmental: Seasonal	❑ LATEX Sensitivity

PAST OCULAR HISTORY:

Circle any applicable eye conditions.

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

FAMILY HISTORY:

Do any of your family members suffer from any of the following?

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

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

Hobbies _____

Please complete the following page

OCULAR HEALTH EVALUATION AGREEMENT

This office will make every attempt to perform a complete retinal evaluation with every 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. This procedure 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. In certain cases, a dilation exam must be performed in addition to the Optomap. If dilation is required, the doctor will inform you during the examination.

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 Optomap is **$35**.

Dilating Eye Drops It normally **takes 20 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, it can be rescheduled for a more convenient time if necessary but additional charges will apply unless it is completed within 14 days of the original visit.

By initialing this form, I am consenting to have the Optomap Retinal Scan as part of today's eye exam and eye dilation if necessary. INITIAL _____

CONTACT LENS WEARER AGREEMENT

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. Contact lens fittings are priced according 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 $100	Hybrid Multifocal $120	Hybrid Keratoconus $200	
Gas Permeable Standard $120	Gas Permeable Premium $150		

A contact lens fitting will be performed annually to renew the contact lens prescription. The fitting fee includes **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.

Contact lens prescriptions will be released to the patient after the trial or follow-up period is 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 visits are needed or if its been more than 45 days since the initial fitting. But if it exceeds more 3 months, the doctor recommends that we perform a refraction again, before proceeding. The refraction charge is $35.

One can choose to have a contact lens fitting at a later date but it must be completed within a 3 month period of the comprehensive eye examination and refraction. 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.

Remember contact lens examination fees, as with all other professional fees, are non-refundable. INITIAL _____

MEDICAL VISIT AGREEMENT

Most vision insurance plans only cover routine yearly eye examinations but do not cover visits due to medical problems such as red eyes, pink eye, corneal problems due to contact lens overwear or foreign bodies. Therefore, Medical Visits will be and out of pocket expense since this practice chooses not to file claims to medical insurances. We will provide you with a detail 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 be a $20 charge per visit. INITIAL _____

INSURANCE OR SELF-PAY FEE FOR SERVICES AGREEMENT

Insurances rarely fully cover entire exams, contact lens evaluations, contact lens materials, medical visits and professional fees for evaluations. Our office staff will make every effort to verify your benefits but **verification of benefits is not a guarantee of payment.** Therefore, any other option for payment must be presented at check-in. I understand that I am fully responsible for my bill for the professional services to be rendered. I have presented my insurance card and benefits have been explained. If I am am not eligible or are eligible for less than full coverage, **my signature indicates that I agree to be financially responsible for the balance not paid by my insurance plan.** INITIAL _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

The privacy act established by the government to protect all your medical information requires us to inform you that your medical information is confidential and we can only release it upon your 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**.** INITIAL _____

I _____ have read and understand the presented office policies.
PATIENT'S FULL NAME

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