Drs. Thomas, House & Associates

Optometrists

7745 Ballantyne Commons Pkwy • Suite 101 ♦ Charlotte, NC 28277
704-841-3937 ♦ Fax: 704-841-3964

PATIENT INFORMATION (PLEASE PRINT) **DATE:** ______________

Patient's Name Birthdate Sex

Email Address Other household members who are patients here

Patient's Address (Street, City, Zip) Home Phone #

Occupation or student Employer or school Phone #

Spouse or Parent's name Address (if different)

Health Insurance Company Insured's Name Policy or Group #

Because of varying coverage, we do not accept assignment on all insurance plans.

Medication presently taken Family Physician

Allergies to medicines, pollens, chemicals, hayfever, etc. Female — Pregnant?
Birth Control Pills? (causes dry eyes)

What is your reason for coming in today?

Have you or any family members had any of the following?	You	Blood Relatives	Have you had any of the following? Explain when.
Cataracts			Watery eyes
Glaucoma			Burning eyes
Retinal detachment			Itchy eyes
Eye disease			Red eye
Eye surgery			Eye pain
Diabetes			Problem headaches
High blood pressure			Double vision
Heart problems			Eye injury
Convulsions /Epilepsy			Flashes of light
Thyroid			Head trauma

Age you began wearing Types of contact lenses tried ______________

Glasses ______________ Last date contact lenses were worn ______________

Contact lenses _______ Have you had problems or allergies to solutions? ______________

Are you interested in wearing contact lenses? Current Solutions ______________

Hobbies or special visual needs Whom may we thank for referring you to us?

Date of Last Visual Exam & Doctor When was the last time your pupils were dilated during an eye exam?

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

OPTOMAP RETINAL EXAM / DILATION

Our doctors recommend the Optomap retinal exam annually for all of our patients. This exam provides our doctors comprehensive scanned photo images of the back of the eye, the retina, to check that it is healthy and not damaged or showing signs of diseases such as retinal detachments, tears, or age-related macular degeneration. The Optomap exam can also detect signs of other diseases that can affect not just your eyes, but also your overall health. These include high blood pressure, high cholesterol, and diabetes. This exam provides a permanent record to compare and track potential eye diseases. The Optomap is fast, easy, and comfortable and can usually be performed without the need for dilation. The fee for this exam is not included in the fees for a routine eye exam and is the responsibility of the patient.

The need for the use of dilation drops to allow a more comprehensive view of the retina will be discussed with the patient by the doctor. The effects of dilation on many patients include discomfort when reading and increased sensitivity to light. These effects usually last for a few hours before beginning to diminish. If this is going to present functional difficulty for a patient, and the patient does not have an emergency condition, the doctor may discuss rescheduling the dilation for another time.

INITIAL AND SIGN TWO (2) ANSWERS BELOW:

____ I ACCEPT THE OPTOMAP RETINAL EXAM
____ I DECLINE THE OPTOMAP RETINAL EXAM
____ I ACCEPT DILATION (IF RECOMMENDED)
____ I DECLINE DILATION (IF RECOMMENDED)
____ I WOULD LIKE TO RESCHEDULE DILATION (IF RECOMMENDED)

SIGNATURE________________________________ DATE_________

SIGNATURE OF PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR___________________________________ DATE_________

INSURANCE

Our office participates in a limited number of insurance plans. Your plan is an agreement between you and your insurance provider. Any co-payments required by your plan are due at the time services are rendered. Any portion of your bill not covered or not paid by your insurance provider is the responsibility of the patient (or patient's responsible party). Contact lens evaluations, Optomap retinal exams, and other specialty testing are usually the responsibility of the patient. Insurance provider information must be provided at time of service. No claims will be submitted by our office after such time.

I acknowledge I have read and understand the above regarding my insurance.

Signature of patient (or responsible party):________________________________