Eye Site Vision Center Patient Information

VISIT OUR WEB SITE at WWW.EYESITEVISION.COM

Mr. Mrs. Ms. First Name _____M_____ Last Name_____Suffix: _____

Address_____ Apt/Bld _____ Zip_____ City _____State _____

Date of Birth _____ Age: _____ Gender: Male or Female Social Security #_____

Drivers License #: _____ Home Phone (_____) _____

Work Phone: (_____) _____ Cell phone (_____) _____

Emergency contact_____ Phone #_____

Relatives (family) who are patients here _____ E-Mail_____

Employer (School) _____Occupation (Grade)_____

Insurance _____Type _____Policy ID #_____ Group #_____

Who may we thank for referring you? _____

TV Location Newspaper Yellow Pages Yellow Page-Companion Advertisement Dr. Referral

Personal Eye Information (Please Circle)

Date of last eye exam? _____ Is this exam for contact lenses? Y or N Do you wear glasses? Y or N
Have you worn contacts before? Y or N If yes, what Type: _____
Eye Surgery Y/ N Type_____ Eye Injury Y/ N Type_____
Glaucoma Y/ N Cataracts Y/ N Dry Eye's Y/ N Blurred Vision Y/N

Patient Medical Information (Please Circle if you have problems with any of the following)

Gastrointestinal Y / N Nervous System Y / N Blood/Lymph Y / N Headaches Y / N
Ears/nose/throat Y / N Endocrine (glands) Y / N Cardiovascular Y / N Respiratory Y / N
Musculoskeletal Y / N Diabetes Y / N Skin Y / N Allergies Y / N
Allergic to Medications Y / N Explain_____
Date of last tetanus shot? _____ Do you have an Advance Directive for health Care? _____
List Operations _____
Other Health Problems? _____
Current Medications_____
Do you smoke? _____ Use Alcohol? _____ Other Substance? _____
If you answered yes to any of these, please explain_____

Family History (Please Check)

Name of family Doctor? _____Phone (_____) _____
High Blood Pressure Y/N Relation _____ Retinal Detachment Y/N Relation_____
Diabetes Y/N Relation_____ Cataracts Y/N Relation_____
Glaucoma Y/N Relation_____ Macular Degeneration Y/N Relation_____
Other Eye Conditions? Y/N What kind_____Relations _____

Dilation (eye drops to enlarge pupil) should be performed to ensure the best eye care. It is somewhat limiting to view the pupil without dilation of the eye. Patient's age and condition of the eyes will determine subsequent dilation procedure.

Dilation has the tendency to make eyes more sensitive to the light. These temporary effects last approximately three hours and may impair reading.

Examination of the external structures of the eye gives the Doctor important information about the health of your eye. Hypertension, arteriosclerosis, diabetes, glaucoma, and cataracts are some of the conditions detected during your eye exam.

_____No, I do not want this procedure done at this time I understand the importance of having my eyes dilated but do wish to NOT have this procedure done at this time and aware that it is my responsibility to schedule a return visit within two weeks from today, if I would like to have it done at a later date.

The Visual Field analyzer can detect diseases such as pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to vascular problems or medications.
We strongly recommend that all our patients receive this evaluation. It is especially important for those **patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, and a high spectacle prescription, retinal problems or have a family member who suffers from glaucoma or retinal problems.**

This state-of-the-art procedure requires an additional 5 minutes of your time and there is a nominal fee of $10.00.

I understand the importance of the Visual Field screening and understand this test would be in my best interest. Please initial below to have this procedure done today.

_____To include the Visual Field test with my Annual Eye Health Examination.

OFFICE FINANCIAL POLICY:

SPECTACLES: We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription. Also, all spectacle lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. **For all these reasons, cash refunds are not possible.** At the doctors' discretion, patients who are not satisfied with the vision in their new glasses would have their prescription adjusted at no cost, within 30 days of the original purchase date. Cash refunds are not available on progressive lenses. However, any patient who fails to adjust to their new progressives will have their prescription remade one time into a lens of their choice at no additional charge.

CONTACTS: All patients seeking a follow up appointment for lens prescription finalization later than 3 months from the initial fitting may be charged a re-fitting fee. There are no returns on contact lens supply purchases, only exchanges or store credit. Some specialty contact lenses may require a deposit or custom order fee to be paid before placing the order.

I understand that I am financially responsible for all charges whether or not paid by said insurance.
Please remember that insurance is considered a method of reimbursing for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to know your insurance and pay any deductible amounts, coinsurance, or any other balance not paid for by your insurance.

In order to control your cost of billings, we request that our charges be paid in full at the conclusion of each visit.

We require a 24hr notice for cancellations of any appointment made. If an appointment is canceled without 24hr notice, there will be a $25.00 cancellation fee.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any claim.
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, and other health plans to Eye Site Vision Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. If this amount is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

Signature (Patient/Guardian): _____ Date: _____, 201_____

THANK YOU FOR CHOOSING EYE SITE VISION CENTER!
WE PROVIDE EXCELLENCE IN EYE CARE