

Welcome to Carrollton Eye Care! Please Fill Out Completely

Today's Date: ____/____/____

Patient's Name (Mr. Mrs., Ms, Dr): _____ Prefer to be Called _____

Phone Number (____) _____ - _____ Date of Birth: ____/____/____ Age: _____

Address: _____ APT#: _____ City: _____

State ____ Zip: _____ Occupation _____ Employer _____

Email Address: _____

Parent (if under 18) or Responsible Billing Party _____ Phone: (____) _____ - _____

Address: _____ APT#: _____ City: _____ State ____ Zip: _____

Medical Insurance: _____ ID#: _____ Vision Ins.: _____ ID#: _____

Primary Insured's Name & Social Security#: _____ & _____ - _____ - _____ Patient's Social Security#: _____ - _____ - _____

Primary Insured Date of Birth ____/____/____ Primary Insured's Employer _____

PLEASE READ AND INDICATE YOUR CHOICE TO PERFORM THESE RECOMMENDED ADDITIONAL TESTS

Retinal Photography - Strongly recommended for all patients that a digital photograph be taken of the inside of your eye for your records.

- This will be used as a baseline for any future subtle changes that may be found.
- This photograph is quick, painless, and **no dilation is necessary**. The fee for this test is **\$25.00**

Visual Field – A computerized instrument checks for missing areas in your peripheral vision that can be present from a variety of ocular diseases. This test is a **SCREENING** only. Any possible defects can lead to further testing.

- Helps detect: Brain tumors, optic nerve disease, damage to the eye from high blood pressure, diabetes, glaucoma, multiples sclerosis, and better enables us to diagnose cause of headaches.
- Recommended for: All new patients; patients with strong prescriptions, headaches, family history of glaucoma or any of the eye conditions listed above.
- Time Frame: **Less than 2 minutes** per eye and **no dilation is necessary**.
- The fee for this test is **\$20.00**.

Dilation - Done with eye drops to dilate, or open, the pupil so the doctor has a good view of the inside of the eye (retina). Dilation is **MANDATORY** for all patients with diabetes, patients with "lazy eye", patients on certain medications, or patients with symptoms of flashes and floaters.

- Helps detect: Internal eye diseases (cataracts, macular degeneration, glaucoma, tumors, retinal tears, holes, detachments, diabetic changes, high blood pressure changes, and others).
- Recommended for: All new patients, patients with autoimmune disease, headaches and routinely every 1-2 years in healthy individuals.
- Time Frame: Adds 20-30 minutes to your visit. It is normal after dilation to experience blurry near vision and sensitivity to light for up to 6 hours. Sunglasses are provided to enable you to drive, if needed.
- The fee for this test is **\$25.00**. Dilation may be covered through your vision or medical insurance as part of a comprehensive eye examination.

Please check which additional test(s) you would like performed today:

_____ Retinal Photography - (\$25.00)

_____ Visual Field - (\$20.00)

_____ Dilation - (\$25.00)

_____ I understand the importance of these tests and although they are recommended by my doctor, I do not wish to have them performed and I release any liability from Carrollton Eye Care with undetected visual issues related to the above tests.

Please read and acknowledge our OFFICE POLICY

1. All professional fees and hardware fees are due and payable at the time of service and are non-refundable.
2. Insurance is filed as a courtesy; you are responsible for deductibles, coinsurances, and any non covered services.
3. A courtesy spectacle recheck if needed must be done within 60 days from your initial exam or there will be a \$25 office visit. After 6 months, a new exam may be required.
4. One courtesy lens power change will be granted if needed within 60 days. If there is a non adaptation to 1st time progressive lens, there is a courtesy refit to a different lens. Additional charges may apply.
5. If applicable, there is a separate spectacle purchase agreement and contact lens exam and evaluation policy

I acknowledge that I have received, read, and agreed to the Office Policy

Parent/Patient's Signature _____ Date _____

**Acknowledgement of Review of Notice of Privacy Practices, Carrollton Eye Care
Authorization Release of Medical Information**

I have been offered and/or reviewed the Notice of Privacy Practices which explains how my medical information will be used or disclosed.

I understand I am entitled to receive a copy of the Privacy Practices.

I authorize release of medical information to my Primary Care Physician or Specialist.

Patient Signature

Date

Patient Representative Signature

Witness

By signing this form, I authorize/acknowledge the following:

General Consent to Treat and Refraction Policy.

I, knowing that I have a condition requiring diagnostic or medical treatment do hereby voluntarily consent to such procedures and care by Drs. Oh or Dr. Buthod or designee as necessary in his/her judgment.

Refraction is the process of determining the eyes refractive error or need of corrective spectacles and/or contact lenses. This is NOT covered by Medicare/Medicaid or some insurances.

I am financially responsible for services rendered, and I understand that I am financially responsible for any portion of the insurance claim that is returned and marked as "Patient Responsibility" or "Member's Responsibility" by my insurance company.

Patient Signature

Date

Doctor Signature

Date

Whom can we thank for your referral?

Friend/Coworker _____

Insurance company _____

Drive By _____

Medical professional _____

Website _____

Other _____

Visual History: Please indicate all that apply

Blurry far Blurry near Tearing Itchy Dryness Pain Discomfort Headaches Glare Contact Lens Discomfort

Are you sensitive to (circle all that apply) Heaters Blowers Air Conditioning Cigarettes Smog Dust Pollen Contacts Contact Lens Solutions Animals

Do you currently wear glasses/contact lenses? Yes No Name of last eye doctor and exam date _____

Medical History:

Primary Care Physician: _____ Phone number: _____ Date of last physical _____

Do you have DIABETES? YES NO How many years? _____ Using Medication? YES NO
Do you have HYPERTENSION? YES NO How many years? _____ Using Medication? YES NO
Do you have Cholesterol Problems? YES NO How many years? _____ Using Medication? YES NO
Females: Are you Pregnant/Nursing? YES NO

Medications: (Please list any and all Medications including Over the Counter, Homeopathic, Birth Control or Remedies): _____

Are you ALLERGIC to Medications? YES NO I am allergic to: _____

List and date all Major Injuries, Surgeries, and Hospitalizations you have had:

Review Of Systems (ROS): Do you have Current or Past problems with:

Constitutional: Fever, Weight Loss, Appetite YES NO
Integumentary: Skin conditions/disorders YES NO
Neurological: Headaches, Migraine, Seizures YES NO
Endocrine: Thyroid, Diabetes YES NO
Ears, Nose Throat: Allergies, Sinus, Cough, Dry Throat/Mouth YES NO
Respiratory: Asthma, Emphysema, Bronchitis YES NO
Vascular: Hypertension, Stroke, Heart Pain YES NO
Gastrointestinal: Diarrhea, Constipation YES NO
Genitourinary: Genitals, Kidneys, Bladder YES NO
Bones/ Joints: Rheumatoid Arthritis, Muscle Pain YES NO
Lymphatic/Hematologic: Anemia, Bleeding YES NO
Allergic Immunologic: Allergies, Immune YES NO
Psychiatric: Depression, Anxiety YES NO

Ocular ROS:

Sudden Vision Loss YES NO R L
Blurred Vision YES NO R L
Loss of Side Vision YES NO R L
Double Vision YES NO R L
Floaters YES NO R L
Flashes of Light YES NO R L
Mucus Discharge YES NO R L
Redness YES NO R L
Gritty Feeling/Dryness YES NO R L
Itching/ Burning YES NO R L
Tearing/Watery YES NO R L
Glare/Light Sensitivity YES NO R L
Eye Pain/ Discomfort YES NO R L
Haloes at Night YES NO R L

Family History:

Blindness YES NO
Cataracts YES NO
Glaucoma YES NO
Macular Degeneration YES NO
Retinal Disease YES NO
Arthritis YES NO
Cancer YES NO
Diabetes YES NO
High Blood Pressure YES NO
Heart Disease YES NO
Kidney Disease YES NO
Thyroid Disease YES NO

Relationship to you (parents, grandparents, siblings):

Any Other? Explain: _____

Social: (this information is strictly confidential, you may discuss this part with the doctor) Check here to discuss with Doctor

Do you drive? YES NO Do you have visual difficulty driving? YES NO Explain _____
Use of tobacco products? YES NO
Use of alcohol products? YES NO
Use of illicit drugs? YES NO
Have you been exposed to any Infectious Disease? (HIV, STD's, Hepatitis, TB, ect.) YES NO

Reviewed by (Doctor Initials): _____ Jane Oh O.D. Aaron Buthod O.D.