

*Welcome to Carrollton Eye Care! Please Fill Out Completely*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name ( Mr. Mrs., Ms, Dr): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ APT#: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent (if under 18) or Responsible Billing Party \_\_\_\_\_

Address: \_\_\_\_\_ APT#: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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 ON EACH OF THESE RECOMMENDED ADDITIONAL TESTS**

**Visual Field** - This 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.
- The fee for this test is **\$20.00**.

**Dilation** - This is 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, others).
- Recommended for: All new patients, patients with autoimmune disease, headaches and routinely every 1-2 years in healthy individuals.
- In some cases, especially children, this must be done to find the best glasses prescription or to diagnose a problem.
- Time Frame: Adds 15-20 minutes to your visit. It is normal after dilation to experience blurry near vision and sensitivity to light for a few 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 you would like performed today:**

\_\_\_\_ Visual Field (\$20.00)

\_\_\_\_ Dilation (\$25.00)

\_\_\_\_ Visual Field and Dilation (\$45.00)

\_\_\_\_ I understand the importance of both visual field testing and dilation and although both are recommended by my doctor, I do not wish to have either test performed and 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. A courtesy spectacle recheck 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.
3. One courtesy lens power change will be granted if needed within 60 days. If there is a non adaptation to 1<sup>st</sup> time progressive lens, there is a courtesy refit to a different lens. Additional charges may apply.
4. Contact lens evaluations include 3 follow ups visits within 60 days. There will be a \$25.00 charge per office visit after 60 days or more than 3 visits. After 6 months from your initial exam another complete eye exam will be required
5. Contact Lens refits to a different lens incurs another evaluation fee.
6. Spectacles sales are final.
7. Unopened, unmarked, unexpired contact lens boxes are exchangeable.

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 most insurance.

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

**Circle which eye(s)**

R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L  
R L

**Family History:**

Relationship to you (parents, grandparents, siblings):

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 \_\_\_\_\_

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

