WELCOME TO OUR OFFICE

Patient _____ Birthdate _____/_____/_____ Last 4 SSN_____

Address _____ City _____ State _____ Zip_____

Mobile Phone _____ Secondary Phone _____

Email address _____ Screen time (hrs/day) _____

Occupation _____ Hobbies_____

Medical Insurance _____	2ND Insurance_____	Vision Plan _____
Member ID _____	Member ID _____	Member ID _____

Policy Holder ☐ self Other _____ Policy Holder Date of Birth ____/____/_____

Who can we thank for referring you?_____

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the "Patient" or "Patient's Legal Representative", have been presented with the Notice of Privacy Policy of My Eye Care LLC, and have been offered a copy of such policy to keep for my records. *(Upon request, a personal copy of the policy may either be emailed or dispensed in person)*

ACCEPTANCE OF INSURANCE & FINANCIAL RESPONSIBILITIES

As a service, My Eye Care verifies and files insurance claims on behalf of their patients. However, I understand what may be quoted as my portion of financial responsibility (co-payment and/or co-insurance) is only an estimate provided by my insurance carrier. I agree to be responsible for what insurance does not cover for the services rendered. I realize that insurance benefits must be presented and verified at the time of service date. We cannot refund you for insurance benefits that were not verified at the time of service date.

My Eye Care strives to guarantee their patients' complete satisfaction. Our doctors and staff promise to provide the best customer service possible, and to attempt to resolve any conflicts or concerns that may arise. However, I understand that all professional fees collected are ultimately non-refundable.

By signing this form, I acknowledge that I understand all above:

X _____

Signature of patient (or parent/guardian) Date

FOR OFFICE USE ONLY:

MEMBER ID _____

PATIENT: ☐ NEW ☐ ESTABLISHED

BILL TO: ☐ OOP ☐ VISION _____ ☐ MEDICAL _____ _____

EXAM TYPE: ☐ Comprehensive ☐ Medical: Level: 1 2 3 4 5 ☐ Post-op

☐ **CONTACT FITTING:** Standard Presbyopic RGP Myopia Control _____

☐ **RETINAL PHOTO:** Screening Medical

☐ **OCT:** Retina Macula ONH Ant Seg 3D WIDE _____

☐ **VISUAL FIELD:** Screening Medical: 92081 92082: 10-2 92083: 24-2 30-2 _____

☐ **DFE** (Dilated Fundus Exam) ☐ **Refraction / RX Check** ☐ **Other:** _____ _____

SRx: OD:_____ **RTC:** _____ d w mo yr Discount _____

OS:_____ Add +_____ For: _____ **TOTAL:** _____

HEALTH HISTORY

Reason for today's exam: _____

Last eye exam (year): _____ Name of last eye doctor: _____

Last medical exam:_____ Location: _____ Medical doctor: _____

Do you wear glasses? ☐Y ☐N When do you wear them? ☐All day ☐Other: _____

Are you interested in contact lenses? ☐Y ☐N

Have you worn contact lenses? ☐Y ☐N

CL brand and Rx: _____

PERSONAL HISTORY (please check all that apply)

☐ Diabetes: ☐Type 1 ☐Type 2
Year diagnosed: _____
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Condition

☐ Thyroid Condition
☐ Blindness
☐ Cataracts
☐ Other Medical/Eye conditions: _____
☐ Medical/Eye surgeries: _____

☐ Macular Degeneration
☐ Glaucoma
☐ Lazy Eye/Eye Turn

☐ Blur: Distance ☐Near
☐ Eye Pain
☐ Eye Injury

☐ Eye Itch
☐ Eye Burn or Tearing
☐ Double Vision

☐ Floaters or Spots
☐ Eye Strain/Headache
☐ Other: _____

FAMILY HISTORY (please check box and **list family member**)

☐ Diabetes: _____ ☐ Blindness: _____ ☐ Macular Degeneration: _____
☐ High Blood Pressure:_____ ☐ Cataracts: _____ ☐ Lazy eye: _____
☐ Other:_____ ☐ Glaucoma:_____

Please list ALL current medications (including eye drops): _____

_____

_____

Medication Allergies: _____

Are you pregnant? ☐ No ☐ Yes, trimester: _____ Are you nursing? ☐ No ☐ Yes

Tobacco used? ☐ No ☐ Former ☐ Yes, type/amount/frequency: _____

Alcohol consumption? ☐ No ☐ Yes, amount/frequency: _____

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X _____

Signature of patient (or parent/guardian) Date

DILATED RETINAL EXAM

Eye dilation allows for a more comprehensive examination of the eye's internal structures, aiding in the early detection of eye conditions such as diabetic retinopathy, macular degeneration, and glaucoma. It enables healthcare professionals to provide better assessments and potentially prevent vision loss by initiating timely treatment. Our doctors recommend this tests for all patients.

After instilling eye drops, pupils will be dilated after 20-30 minutes. Temporary side effects of dilation include blurred vision especially at near, light sensitivity, difficulty focusing, and mild discomfort that lasts 4-6 hours. Even with sunglasses, it may be difficult driving and continuing your daily activities. During this time, exercise caution when walking down steps, driving, operating machinery, or performing other task that may present a risk of injury to yourself or others.

A very rare side effect of the dilation drops is angle closure. Symptoms of angle closure include eye pain, redness, severe headaches, vision loss, cloudiness, and/or nausea. If this occurs, please contact our office or go to the emergency room immediately.

The dilation is included at the time of your examination.

YES _____ I consent to have the procedure, and I understand the risks and benefits of pupil dilation.

NO _____ I do not wish to undergo the dilation, but the benefits have been adequately explained to me.

OCT SCAN & RETINAL PHOTO IMAGING

1. Early Detection: OCT and retinal photo imaging enable early detection of various eye conditions, including glaucoma, macular degeneration, diabetic retinopathy, and other retinal disorders. Detecting these conditions early allows for timely intervention and treatment. Our doctors recommend this tests on all patients especially for new patients or family history of eye disease.
2. Precision and Detailed Imaging: The high-resolution cross-sectional images obtained through these tests provide detailed insights into the structures of the eye, allowing healthcare professionals to accurately assess the health of the retina, optic nerve, and other critical eye components.
3. Non-invasive and Painless: The procedure is quick, non-invasive, and painless (dilation not required), involving no physical contact with the eye. This makes it a comfortable and safe method for evaluating eye health without causing discomfort to patients during the screening process.

The fee for the bundled screening is $45.00. Most insurances do not cover this procedure.

YES _____ I consent to have retinal photographs taken.

NO _____ I do not consent to have retinal photographs taken.

VISUAL FIELD SCREENING

The visual field screening tests the integrity of the optic nerve pathway. It is a non-invasive computerized test which helps detect blind spots that could be signs of glaucoma, retinal disease, and neurological disease. It can also aid in determining causes of headaches.

The fee for Visual Field Screening is $21.00. Insurances do not cover this procedure.

YES _____ I consent to have the visual field screening.

NO _____ I do not consent to have the visual field screening.

By signing this form, I acknowledge that I understand all above:

X _____

Signature of patient (or parent/guardian) Date