Premier Family Eye Care

Welcome back to our office! We want to continue to provide you with the very best in vision care. In order for us to serve you better, we need to review your information. Please complete the following data for our records.

PATIENT INFORMATION

First Name: _____Last Name: _____ Middle Initial: _____Preferred Name: _____

Address: _____

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** _____

Alternate number:_____ E-mail address: _____

PRIVACY / FINANCIAL POLICY

OFFICE POLICY ON PAYMENT: *I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that only one vision plan may be used for exam/materials per visit-per patient.*

SIGNATURE: _____ **DATE:** _____

EYE HEALTH HISTORY

How can we help you today? Please circle to indicate if you currently have any of the following symptoms, please indicate which eye:

Annual Examination	Eye Injury	Light Sensitive	Discharge from Eyes
Burning Eyes	Watering Eyes	Red Eyes	Dry Eyes
Blurred Vision- Near	Sandy/Gritty Eyes	Itchy eyes	Temporary Loss of Vision
Blurred Vision- Far	Headaches or Migraines	Seeing Halos	Fluctuating Vision
Seeing Flashes	Floaters, Spots	Double Vision	Eye Strain
Eye Turn	Glaucoma	Cataracts	Other _____

Are you interested in wearing contact lenses? **Yes** **No**

How many hours per day do you work on a computer? _____

Are your eyes sensitive to sunlight? **Yes** **No**

Do you wear sunglasses? **Yes** **No**

Have you had LASIK? **Yes** **No**

Are you interested in discussing LASIK? **Yes** **No**

CURRENT VISION

GLASSES Do you currently wear glasses? **Yes** **No** ***If yes, answer the questions below; if no, continue to contact lenses section.***

How old are your glasses: _____

Are you interested in getting new glasses today? **Yes** **No**

Problem with reflection or glare? **Yes** **No**

Want information on thinner / lighter lenses? **Yes** **No**

CONTACT LENSES: Do you currently wear contacts? **Yes** **No** ***If yes, answer the questions below; if no, continue to Medical History.***

Interested in newer contact lens technology? **Yes** **No**

Describe any problems with your contacts:_____

How often do you replace your contact lenses? _____

What solution do you use? _____

MEDICAL HISTORY

Please list your Primary Care Physician: _____ **Are you pregnant or nursing?** **Yes** **No**

Please list any changes in your medical history: _____

Please list any medications you are currently taking:_____

Please List any drug allergies: _____

List any other allergies: _____

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OPTOMAP® DIGITAL RETINAL IMAGING CONSENT FORM

In our continued efforts to bring the most advanced technology available to our patients, Premier Family Eye Care offers Optomap® digital retinal imaging as part of your comprehensive eye exam. Our doctors highly recommend that you have these images taken today.

Depending on the results, the doctor will determine whether or not you need to be dilated.

The procedure is fast, easy and comfortable. This is not an X-ray or ultrasound procedure; and nothing will touch your eye. We are simply taking a digital picture.

This permanent record is very valuable in assessing the current health of your eye; and for safeguarding the health of specific structures of your eye such as the retina, optic nerve, macula, and blood vessels. In some cases it may detect diabetic eye changes, macular degeneration, and high blood pressure changes. It will also serve as a baseline from which to compare, as we follow your health in subsequent years.

If you voluntarily elect to have these photos taken the fee is **$35**. Routine retinal images are not covered by most vision plans. If a medical diagnosis is determined during your comprehensive exam, retinal photos may be taken of your eye as part of your eye health exam, and therefore may be able to be billed to your medical insurance. There is a higher fee for the photos when they are deemed necessary for medical care as additional medical attention is necessary. You would be responsible for any out of pocket cost including deductible or copay/coinsurance charges as determined by your insurance company.

_____ Yes, I want to have retinal photos taken of my eye for documentation

_____ No, I do not wish to have retinal photos taken, unless doctor determines need to do so

_____ I would like to consult with the Doctor before deciding

Patient Signature:_____ Date: _____

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Contact Lens Evaluation and Explanation of Fitting Fees

Please understand that contact lens services are NOT included in your annual comprehensive eye exam. Your eye exam includes a prescription for eyeglasses, eye muscle tests, glaucoma tests, dilation and full ocular health assessment.

By law, contact lenses must be evaluated annually and properly fit in order for your eye health and vision to be properly maintained. Most insurance companies DO NOT cover this portion. Following the contact lens evaluation or fitting process you will have a current prescription that will expire in 1 year.

Evaluation: No change in brand or power necessary

Annual Evaluation $45 Applies to existing contact lens wearers who, at the end of the exam, the doctor determines that a change in brand and power is **not** necessary. New patients to our office must bring prescription or boxes with them at time of service to qualify.

Contact Lens New fit: Change in brand or power

There are four levels of fittings depending on the complexity of your prescription and lens type required.

Fitting fees include a complimentary pair of contact lenses, lens case, solution, and any follow up visits within 90 days of the ***initial*** contact lens fitting with our doctor.

Level 1 $60 Basic Soft Contact Lens Fit

Level 2 $90 Advanced Soft or Basic Gas Permeable Contact Lens Fit

Level 3 $160 Soft Multifocal/ Monovision or Advanced Gas Permeable Lens Fit

Level 4 $215 Specialty Lens Fit (i.e. Keratoconus Gas Permeable Lenses; not including scleral lenses)

There is a separate **$25** charge required for the Contact Lens Insertion and Removal training by one of our skilled staff

I understand that the fitting fee does not include the cost of the lenses, and that the lens supplies are ordered separately. Contact lens prescriptions will only be released after the initial fitting period is successfully completed and all fees are paid.

I understand even with proper care there are risks to wearing contact lenses, and that those risks increase with improper use. I must follow the instructions given to me by the eye care team about the recommended wear and replacement schedule to ensure the health of my eyes. I agree to remove my lenses at the first sign of problems and call the office immediately if I develop unusual pain or redness.

_____ _____

Patient or Guardian Signature Date