Premier Family Eye Care

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

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____ Preferred Name: _____

Social Security #: _____ Gender: **M** / **F** Date of Birth: ____/_____/_____ Marital Status: **Single** **Married** **Other**

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Alternate number: _____ E-mail address: _____

Whom may we thank for referring you to us? _____

PRIVACY / FINANCIAL POLICY

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Premier Family Eye Care's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Premier Family Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I hereby authorize Premier Family Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.

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.
VISION PLAN COVERAGE: 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 Infection	Eye Injury	Twitching Eyelid
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	Crossed Eyes	Color Vision, Poor	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 LASIK? **Yes** **No**

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with the following conditions? If so, please check the appropriate box:

CONDITION	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT
Diabetes					
High Blood Pressure					
Glaucoma					
Macular Degeneration					

CURRENT VISION

Date of last exam: _____ **Doctor:** _____

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

Do you wear them (circle one): all the time reading/near work distance tasks only How old are your glasses: _____

Are you interested in getting new glasses today? **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 review of systems.***

What is your contact lens brand/power? _____

Describe any problems with your contacts: _____ Interested in newer contact lens technology? **Yes No**

How often do you replace your contact lenses? ☐ **Daily** ☐ **Weekly** ☐ **2 weeks** ☐ **Monthly** ☐ **3 months** ☐ **6 months** ☐ **Annually**

What solution do you use to care for contact lenses? ☐ **Renu** ☐ **Opti-free** ☐ **Clear Care** ☐ **Boston** ☐ **Other:** _____

REVIEW OF SYSTEMS

Ocular/Eye Problems	**YES**	**NO**
Inflammatory disorder	☐	☐
Surgery	☐	☐
Glaucoma	☐	☐
Amblyopia (lazy eye)	☐	☐
Cataract	☐	☐
Retinal problems	☐	☐
Macular degeneration	☐	☐
Strabismus (eye turn)	☐	☐
Patching	☐	☐
Constitutional Problems		
Cancer	☐	☐
Fatigue	☐	☐
Developmental disability	☐	☐
Ears, Nose, Mouth, Throat Problems		
Laryngitis	☐	☐
Dry mouth	☐	☐
Hearing loss	☐	☐
Sinusitis	☐	☐
Neurological Problems		
Cerebral palsy	☐	☐
Multiple sclerosis	☐	☐
Tumor	☐	☐
Epilepsy	☐	☐
Psychiatric Problems		
Depression	☐	☐
Insomnia	☐	☐
Cardiovascular Problems		
Vascular disease	☐	☐
Stroke	☐	☐
Congestive heart failure	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐

Other condition not listed_____

Respiratory Problems	**YES**	**NO**
Emphysema	☐	☐
Bronchitis	☐	☐
Smoker	☐	☐
COPD	☐	☐
Asthma	☐	☐
Gastrointestinal Problems		
Colitis	☐	☐
Crohn's disease	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Genitourinary Problems		
Prostate Disease/Cancer	☐	☐
STD	☐	☐
Kidney Disease	☐	☐
Musculoskelatal Problems		
Ankylosis Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoarthritis	☐	☐
Skin Problems		
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Endocrine Problems		
Diabetes Insulin-Dependent	☐	☐
Diabetes Non-Insulin	☐	☐
Hormonal Dysfunction	☐	☐
Thyroid Dysfunction	☐	☐
Blood/Lymph Problems		
Large volume blood loss	☐	☐
Anemia	☐	☐
Allergy/Immunologic Problems		
Environmental allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐

Are you pregnant or nursing?
Y N

What is your occupation?
_____

List your sports / hobbies:
_____
_____

If you smoke,
how much per day?
_____

Do you consume alcohol ? Y N
If yes, how much do you drink?
_____

Primary Care Physician:
_____

Please list any medications you are currently taking:
_____
_____
_____
_____

List any medicine allergies:
_____
_____

List any other allergies:
_____
_____

Premier Family Eye Care

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: _____

Premier Family Eye Care

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