EYE TO EYE CARE

Your Highlands Ranch Family Eyecare Specialist

Patient Information *(Please Print)* ☐ *No Change Same as Previous Information*

First Name	Last Name		Date	
Address			Occupation	
City	State	Zip Code	Date of Birth / Age	☐ Male ☐ Female
Home Phone Number		Cell Phone Number		
Approximate date of last eye examination		Email Address		

What Brings you to our office today?

Please check all that apply.

☐ Routine, no complaints
☐ Want Contact Lenses
☐ Want glasses

Blur at far…

☐ w/ correction ☐ w/out correction

Blur at near…

☐ w/ correction ☐ w/out correction

☐ Eye strain
☐ Frequent headaches
☐ Double vision
☐ Burning, stinging eyes
☐ Tearing
☐ Red eye
☐ Eye infection
☐ Floaters / flashes

Do you currently?

Please check all that apply.

☐ Wear glasses ☐ Wear contacts

What kind of contacts do you wear?

☐ Daily Disposables ☐ Weekly Disposable ☐ Monthly Disposable

☐ Toric ☐ Hard or Gas Permeable ☐ Bifocal or Mono Vision

Eye Health: Do you now or have you ever had?

Please check all that apply.

☐ Eye injury
☐ Eye surgery or Lasik
☐ Cataracts
☐ Macular Degeneration
☐ Glaucoma

☐ Lazy eye (amblyopia)
☐ Strabismus (eye turn)
☐ Vision therapy
☐ Family history of glaucoma
☐ Other:_____

Personal Health History: Do you have?

Please check all that apply.

☐ Diabetes
☐ High blood pressure
☐ High Cholesterol
☐ Rheumatoid Arthritis
☐ Pregnant

☐ Heart disease
☐ Thyroid disease
☐ Allergies / Hay fever
☐ Other: _____

Are you allergic to any medications?
☐ No ☐ Yes If yes, please list:

Please list all medications you are taking: _____

Retinal Exam: Dilation or Optos

Dilation: Drops are used to enlarge the pupil, allowing the doctor to see a better complete view of the retina. The drops will cause light sensitivity and blurred vision, especially up-close, for approximately four to five hours.

Optos: Optos is a fast, painless, and comfortable digital imaging of the retina. The Optos provides a wide view allowing your doctor to confirm your retinal health, or discover signs of abnormalities. It provides a permanent record of your retina that can be compared and/or reviewed at next years exam. Drops are not required in most cases.

Optos is an additional $25.00
They are recommended every year.

Payment Information

_____ **EXAM COPAY**

This does not include the contact lens Fit/Eval for Contact Prescriptions. The additional fee is ($60-$80).
The Fit/Eval price is subject to change as per Doctors' discretion and/or insurance.

I have answered the above questions to the best of my knowledge. **I understand that I am responsible for payment at the time of service.**

Signed:_____ Date:_____

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Insurance Information

☐ No Change Same as Previous Information

Vision Insurance

Insured's Name: _____ Insured's Date of Birth:_____ Relationship_____

Insured's Employer:_____ Insured's Provider: _____

Insured's Member ID#: _____ Insured's Group Number: _____

Medical Insurance

Insured's Name: _____ Insured's Date of Birth:_____ Relationship_____

Insured's Employer:_____ Insured's Provider: _____

Insured's Member ID#: _____ Insured's Group Number: _____

Acknowledgements

Patient Notification – Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and are subjected to their specific co-pays, deductibles, and co-insurance which will be due at the time or service. In the event you want a routine examination for your eyeglasses or contact lens prescription, I understand it is my responsibility to immediately inform the Doctor so that they can refer me to the appropriate Specialist for any medical concerns.

Financial Acknowledgement

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits and/ medical benefits to go directly to Eye to Eye Care. I authorize Eye to Eye Care to deposit checks received on my account made out to me for services rendered**. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at the time of service does not guarantee payment and any denied services will be balanced and billed to the patient.**

Patients with insurance must present their information to us prior to any service(s)/purchase(s). We will not bill the insurance after the service(s)/product(s) are already performed, therefore, there will be no refund! You may send the receipt to your insurance company and try to get reimbursed yourself. **In the case that a return is needed, there will only be store credit. No monetary refund will be given.**

HIPPA Compliance and Release of Information

Eye to Eye Care is subject to State and Federal regulations. Eye to Eye Care and/or its doctor may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the Optometrist, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carrier, welfare funds and all authorized auditors as specified in the Insurance Carrier Guidelines and referring professionals. Eye to Eye Care follows HIPPA guidelines. A full detailed report of Eye to Eye Care's Notice to Privacy Practices is available upon request.

Consent of Acknowledgements

I have read the "Consent to Treatment", "Financial Acknowledgement", and "HIPPA Compliance and Release of Information" as the Patient, or the Patient authorized representative or general Agent for the purpose of signing this document, herby accept it's terms.

Patient Name *(Please Print)*: _____

Patient/Guardian Signature: _____

Date: _____