

SocialEyes

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____ Sex: M / F DOB: / /
Address: _____ City _____ State _____ Zip _____
Marital Status: SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED How did you hear about us? _____
Home #: () _____ - _____ Mobile #: () _____ - _____ Work #: () _____ - _____ Ext. _____
Email Address (optional): _____ Allow Text/Email Reminder: Y / N
Occupation: _____ Employer: _____

OCULAR HISTORY:

Reason for today's visit: Glasses Exam Contact Lens Exam Other: _____
When was your last eye exam? _____ Optometrist _____
Do you wear glasses? Y / N Do you wear contacts? Y / N If so, hard or soft? _____ Brand? _____
Do you currently use eye drops (prescription or OTC)? Y / N If so, which one(s) do you use? _____

CHECK ALL THAT APPLY:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Blurred Computer Vision | <input type="checkbox"/> Discharge | <input type="checkbox"/> Glare | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Blurred Distance Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blurred Near Vision | <input type="checkbox"/> Dry/Watery | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Retinal Disorder |
| <input type="checkbox"/> Burning/Itching | <input type="checkbox"/> Eye Injuries/Surgeries | <input type="checkbox"/> Loss of Vision | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Flashes | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Floaters | <input type="checkbox"/> Other: _____ | |

MEDICAL HISTORY:

When was your last medical exam? _____ Current Medical Doctor: _____
Do you have any allergies? Y / N If so, please list: _____
Current Medications (prescriptions/OTC): _____
List all major injuries, surgeries and/or hospitalizations: _____
Female Patients: Are you pregnant and/or nursing? Y / N

CHECK ALL THAT APPLY:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal Disorder | <input type="checkbox"/> Migraine | <input type="checkbox"/> Hypo/Hyperthyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Skin Disease | |
| <input type="checkbox"/> Diabetes: Type I / II | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ | |

FAMILY HISTORY:

- Blindness
- Cancer
- Cataract
- Diabetes
- Glaucoma
- Macular Degeneration
- Retinal Disorder

SOCIAL HISTORY:

Do you smoke? Y / N Packs per Day: _____
Do you drink alcohol? Y / N # Days per Week: _____
Do you use illegal drugs? Y / N
Have you ever been exposed to or infected with: Hepatitis/HIV/AIDS/Other? Y / N
If so, please list: _____

VISUAL FIELDS: Additional Cost of \$20

This instrument checks for areas of loss of vision in both central and peripheral areas. Possible defects that may be detected early may include glaucoma, retinal problems, neurological diseases, and brain tumors. It can enable us to better diagnose the cause of headaches.

- YES**, I would like to be tested today
- NO**, I am declining at this time, but am aware of the possible failure to detect any conditions due to the lack of information that may have been provided by this test.

Please note that your vision can change in less than a year. If a follow-up is necessary to re-check your glasses/contact lens prescription, you have a 60 day grace period. After this time, there will be an additional fee of \$30. After 6 months, a full eye exam and/or contact lens fitting will be charged.

If you have read and understand the above policy regarding the follow-up appointment, please initial: _____

INSURANCE INFORMATION: *Please provide insurance card or information to the front desk, if available.*

I hereby authorize all my (or my dependent's) appropriate insurance benefits be paid directly to SocialEyes for products and services rendered. I understand that I am financially responsible for uncovered services and I will make prompt payment for any services not paid or covered by my insurance company. I authorize the above named physician to release any information required to process this claim. I understand that verification of insurance coverage is not a guarantee of payment and that I am responsible for all unpaid charges. I also understand that I am liable for all legal and collection fees. If I choose SocialEyes as an out-of-network provider, they are not responsible if I am not fully re-imbursed and I will have to contact my insurance.

If you have read and understand the above policy regarding Insurance, please initial: _____

HIPAA PRIVACY ACT:

I understand that, under The Health Insurance Portability Accountability Act, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understood The Notice of Privacy Practices.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the practice will provide a current copy of Notice of Privacy Practices upon request.

If you have read and understand the policy regarding HIPAA Privacy Act, please initial: _____

SIGNATURE ON FILE:

- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies
- I understand I am responsible for my bill.
- I authorize my doctor to act as my agent in helping obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I authorize a copy of this authorization to be used in place of the original.

If you have read and understand the above policy regarding signatures, please initial: _____

I have read and understand all the information provided on these forms are correct by my signature below.

PATIENT (GUARDIAN) SIGNATURE _____ **DATE** _____



————— E Y E S T U D I O —————

DIGITAL RETINAL PHOTOGRAPHY

At SocialEyes Eyecare we use the latest technology and state of the art equipment to provide our patients with the most comprehensive eye care In our community. Please take a moment to review this information.

Retinal photography is a non-invasive procedure used to capture an image of the back part of the eye (retina). At Socialeyes Eyecare we use retinal photos to document patients’ retinal conditions and provide baseline data that can be used to follow your health in subsequent years.

Our retinal camera Is able to capture a photo of your retina up to 110 degrees with an un-dilated pupil (no eye drops). Although many patients choose to forgo a traditional dilation (eye drops) in lieu of retinal photos, there is no substitute for a traditional dilation.

Our Doctors highly recommended retinal photos for all our patients, especially those with a history of diabetes, hypertension, glaucoma, headaches, floaters, flashing lights, retinal problems, and high glasses prescriptions.

Some insurance companies will cover the expense of retinal photography. If the procedure is not covered by your insurance carrier, we offer you a same day pay pricing at the rate of \$39. You are responsible for this fee at the time of service.

_____ **Yes**, I consent to retinal photography and agree to pay \$39 for this service.

_____ **No**, I do not consent retinal photography.

PRINTED NAME OF PATIENT _____

PATIENT / GUARDIAN SIGNATURE _____ **DATE** _____