Welcome to SocialEyes Eye Studio!

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 _____

Are you using insurance today (Medical or Vision)? ☐ No ☐ Yes, Name of Insurance _____

Primary Name _____ Primary DOB / / Member ID# _____

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:

- ☐ Blurred Computer Vision
- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Burning/Itching
- ☐ Cataracts
- ☐ Chronic Infections
- ☐ Discharge
- ☐ Double Vision
- ☐ Dry/Watery
- ☐ Eye Injuries/Surgeries
- ☐ Flashes
- ☐ Floaters
- ☐ Glare
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Other: _____
- ☐ Pain
- ☐ Redness
- ☐ Retinal Disorder

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:

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

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 $25

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** _____

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EYE STUDIO

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 date 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 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** _____

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EYE STUDIO

EMAIL PRESCRIPTION CONSENT FORM

Risks of Emailing Patient Prescription

Transmitting patient information poses several risks and the patient should not agree to have his/her/their prescription emailed without understanding and accepting these risks.

The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass
- through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true
- identity of the sender, or to ensure that only the recipient can read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of Using Email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however, we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with having my prescription emailed. I acknowledge the office's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

PRINTED NAME OF PATIENT _____

PATIENT / GUARDIAN EMAIL _____

PATIENT / GUARDIAN SIGNATURE _____ **DATE** _____