WELCOME TO OUR OFFICE

In order for our doctors to provide the best care for you, please answer the following questions:

Date______________How did you hear about us?____________________________________

Name_______________________________________Date of Birth____________Age______

Spouse's Name_______________________________Spouse's Work#_____________________

Home Address____
Street City Zip

Home Phone______________________Work Phone__________________________________

If patient is a minor, name of parent or guardian______________________________________

Do you presently wear glasses, contacts, both or neither? (Please circle appropriate choice)

List any medications that you are taking____

____

List medications that you are allergic to____

Name of Medical doctor__________________________Phone__________________________

Name of nearest relative or person that we could contact in case of an emergency:
___________________________________Phone_____________________________________

Name of vision insurance______________________________ID#_______________________

Name of health insurance______________________________ID#_______________________

I will be paying today with the following:
Cash_____Check_____Charge Card_____(Please list driver's license # if you are paying with a check___________________)

I understand and agree that regardless of insurance I am ultimately responsible for the balance of my account for any services that are rendered. I have read all the information regarding the financial policy of this office and agree to abide by it. I certify that the information given above is true and current to the best of my knowledge. I will notify you if this information changes.

Signature of responsible party____

Please read and sign the financial policy on the back. Thanks!

PATIENT QUESTIONNAIRE

Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name ____

Name ____

Please list the family members or significant others, if any, whom we may inform about your medical condition in an emergency:

Name ____Phone number ______________

Name ____Phone number ______________

Please print the telephone number where you want to receive calls about your appointments, test results, or other health care information if other than your home phone number:

____

May confidential messages (i.e. appointment reminders, information about glasses or contacts) be left on your telephone answering machine or voicemail or sent via fax?

Yes ______ No ______

____ __________________

Patient/Guardian signature Date

OUR FINANCIAL POLICY

A deposit on glasses is a customary fee of 50% of the total of the glasses and will be expected at the time of the order. The remaining balance is to be paid in full when you pick up your glasses. We are a provider for most insurances. If you would like us to file your insurance, please let the front desk know. Please try to call 24 hours in advance to cancel an appointment whenever possible. There will be a service charge of $25.00 on all returned checks.

___________________________________ __________________

Signature Date

RETINAL PHOTOGRAPHY

Retinal photography is a painless procedure for the early detection of retinal problems such as those associated with diabetes, glaucoma, macular degeneration, and optic nerve disease. A digital camera is used to take pictures of your retinas. The photographs document your retinal condition and provide excellent baseline data for your doctor. This test is recommended for all our patients over 35 but is especially necessary for those with a history of high blood pressure, diabetes, retinal problems, headaches, floaters, flashing lights, and a strong prescription for glasses. There is an additional charge of $60 for this procedure. Please check the appropriate line and sign at the bottom:

__________ Yes I do want the retinal photography
__________ No I do not want the retinal photography

Signed: _____________________________________

Please note: Although this test is optional for some people, as it represents preventative health care, for others the documentation is required for the purpose of ruling out certain eye conditions. This would possibly be payable by your medical insurance.