

WELCOME TO OUR OFFICE

In order for Dr. Garber, Dr. Harris, and Dr. Ellington 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 State Zip

Home phone _____ Work phone _____ Cell phone _____

If patient is a minor, name of parent or guardian _____

List any medications that you are taking _____

List any 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 ___ Debit ___ 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 following page. 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.