WELCOME TO OUR OFFICE
CREEKSIDE FAMILY EYECARE

Last name_____ First Name _____MI_____

Address_____

City, State, Zip_____

Phone (cell/hm)_____Email _____

Date of Birth _____Age_____ Referred by_____

Occupation_____Employer_____

Medical insurance: _____Type: □ PPO □ HMO

Vision insurance: _____

Name of primary insured: _____Primary's Date of Birth: _____/_____/_____

Primary's Social Security # or ID: _____

Date of last eye exam _____Name of last Eye Doctor_____

Have you ever worn contacts? □ Yes □ No If so, what type? _____
Are you interested in contacts? □ Yes □ No

Reason for visit today / Chief medical complaint:

_____

_____

Do **you** or anyone in your **immediate family** have a history of the following:

High Blood Pressure	□ Self	□ Family:_____	Glaucoma	□ Self	□ Family:_____
Diabetes	□ Self	□ Family:_____	Cataract(s)	□ Self	□ Family:_____
Heart condition	□ Self	□ Family:_____	Macular Degeneration	□ Self	□ Family:_____
Thyroid	□ Self	□ Family:_____	Eye Injury/Surgery	□ Self	□ Family:_____
High Cholesterol	□ Self	□ Family:_____	Other Eye disease	□ Self	□ Family:_____
Currently Pregnant	□ Self	(if applicable)	if so, which one? _____		

Other health issues: _____ □ Self □ Family:_____

Please list any medications you are taking: _____

_____

Please list any allergies you have: _____

Social history: (smoking, drinking, recreational drugs)_____

If so, frequency per week: _____

We are committed to early detection and prevention of eye diseases. All patients will receive the Optomap retinal screening annually unless a waiver is signed. Our doctor wants ALL patients to have a digital image of the retina EVERY year. We strongly recommend that all of our patients also have the OCT iWellness exam as part of their comprehensive vision examination.

Optomap: Don't like eye drops or blurry vision? An Optomap retinal scan provides the doctor ultra-wide views of your retina in a single capture. Using this scan, we can detect retinal problems such as macular degeneration, glaucoma, retinal holes/tears/detachments, diabetes, high blood pressure, and eye cancers. There are no side effects and provides a permanent record of your eyes. The additional fee for this test is **$39.**

☐ The **iWellness optical coherence tomography** (**OCT**) is a non-invasive imaging test that uses light waves to take cross-section pictures of your retina and optic nerve. It can detect earlier changes in the retina associated with glaucoma, macular degeneration, and diabetic retinopathy. The additional fee for this test is **$30 and is not covered by vision insurances.**

I understand that without these tests certain eye diseases and conditions may go undetected. I agree to assume all risks associated with refusing these tests and release Creekside Family Eyecare from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye condition due to lack of diagnostic information which could have been obtained with these tests.

ALL FEES FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND DUE AT TIME OF SERVICE.
ALL EXAMS INCLUDE A 3-MONTH FOLLOW UP PERIOD. CHARGES APPLY THEREAFTER.

This form is consent from the patient or guardian to allow Creekside Family Eyecare to file benefits on your behalf. Please note that your insurance provider may not cover some services rendered. **I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance carrier.** I hereby authorize Creekside Family Eyecare to file my vision and/or medical benefits on my behalf, and therefore, I authorize my insurance carrier to direct payment of benefits to our office.

There is a restocking fee for all returned frames, lenses, and contacts. Materials must be returned within 30 days of the purchase date. Most frames have a one year warranty for defects by the Manufacturer only. Warranty is voided if the frame is discontinued. Only one remake of lenses is allowed with in 60 days from the date of purchase. All other remakes will be at full charge to patient.

A copy of your contact lens prescription will be provided at the completion of the contact lens evaluation and can also be obtained via an online portal. Contact our office for your login information.

NOTICE OF HIPAA PRIVACY POLICY

This form in posted in the office and we will gladly provide you with a copy of this notice if you would like to keep one for your personal records. This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Examples of uses of your health record information include patient recall, prescription verification or request, and for co-management with another health professional. Signing below indicates that you have been made aware of our privacy practices.

Signature_____Date_____

If patient is a minor, relationship to patient_____