



## WELCOME TO OUR OFFICE

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Patient First Name:	
Patient Last Name:	
MI:	
Address:	
City:	
State:	
Zip:	
Cell Phone:	
Home Phone:	
Email:	
Date of Birth:	
Age:	
SS# (last 4):	
Occupation:	
Employer:	
Medical insurance & ID#:	
Type:	<input type="checkbox"/> PPO <input type="checkbox"/> HMO
Vision insurance:	
Name of primary insured:	
Primary's Date of Birth:	
Primary SS# (last 4):	
Date of last eye exam:	
Name of last Eye Doctor:	
Have you ever worn contacts?	<input type="radio"/> Yes <input type="radio"/> No

If so, what type?

Are you interested in contacts?

Yes  No

Does your vision fluctuate between blinks?

Yes  No

Are you concerned about your child's nearsightedness worsening?

Yes  No

Do your eyes feel tired or strained during your workday?

Yes  No

Do you ever feel you have trouble hearing?

Yes  No

Reason for today's visit?:

Do you or your immediate family (if family, which member?) have a history of the following:

High Blood Pressure

Self

Family:

Diabetes

Self

Family:

Heart condition

Self

Family:

Thyroid

Self

Family:

High Cholesterol

Self

Family:

Glaucoma	
	<input type="checkbox"/> Self
	<input type="checkbox"/> Family:
Cataract(s)	
	<input type="checkbox"/> Self
	<input type="checkbox"/> Family:
Macular Degeneration	
	<input type="checkbox"/> Self
	<input type="checkbox"/> Family:
Eye Injury/Surgery	
	<input type="checkbox"/> Self
	<input type="checkbox"/> Family:
Other Eye disease	
	<input type="checkbox"/> Self
	<input type="checkbox"/> Family:
Currently Pregnant	<input type="checkbox"/> (if applicable)
Other health issues:	
	<input type="checkbox"/> Self
	<input type="checkbox"/> 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/OCT exam annually unless a waiver is signed. Our doctor wants ALL patients to have a digital image of the retina EVERY year for your ocular health.

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.

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 both taken the same day is \$49.

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 EXAMS INCLUDE A 3-MONTH FOLLOW UP PERIOD. CHARGES APPLY THEREAFTER.

**ALL FEES FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND DUE AT TIME OF SERVICE.**

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.

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 within 60 days from the date of purchase. All other remakes will be at full charge to patient. There is a 30% restocking fee for all returned frames, lenses, and contacts. Materials must be returned within 30 days of the purchase date. No exceptions.

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 is 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:	
If patient is a minor, relationship to patient:	