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:

____

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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. We strongly recommend that all of our patients receive the fundus photo, dilation, and visual field test as part of their comprehensive vision examination. Please check boxes to do corresponding tests.

Dilation allows the doctor a more thorough examination of the inside of the eye. Included as part of the exam. Causes light sensitivity and blurry near vision for 4 hours.

Fundus photo: Don't like eye drops or blurry vision? A retinal fundus photo provides the doctor with a view of your retina in a single capture. There are no side effects and provides a permanent record of your eyes. The additional fee for this test is **$25.**

A **visual field test** checks your central and side vision for early vision loss from eye diseases and neurological issues. The additional fee for this test is **$15 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.

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________________________