

WELCOME TO EYE CARE 4 TX

Patient Name: _____ Date of Birth ____/____/____ Age: _____
Address: _____ Apartment or Suite #: _____
City: _____ State: _____ Zip Code: _____ Social Security Number: _____ - _____ - _____
Sex (circle one): Male/Female Occupation/Employer: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Parents Name if under 18 years of age: _____
Email: _____

Method of Payment: ____ Cash ____ Credit or Debit Card (Visa/MasterCard/Discover) WE DO NOT ACCEPT CHECKS.
How did you find out about us? ____ Internet ____ Walked by ____ Wal-Mart
____ Other (Please Specify) _____

PATIENT HISTORY

Date of last Eye Exam: _____ Main Reason for today's Visit: _____

List Medication's you are taking (including non-prescription):

List Allergies/Allergies to Medication's:

Please check any condition that applies to yourself or any members of your immediate family:

	Self	Family		Self	Family
Diabetes	_____	_____	Cataracts	_____	_____
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Heart Disease	_____	_____	Macular Degeneration	_____	_____
Respiratory Problems	_____	_____	Retinal Detachment	_____	_____
Cancer	_____	_____	Turned Eye's	_____	_____
Head Trauma	_____	_____	Lazy Eye	_____	_____
HIV Positive	_____	_____	Eye Surgery	_____	_____
Excessive Headaches	_____	_____	Eye Injury/Trauma	_____	_____
Thyroid	_____	_____	Floaters	_____	_____
Lung Disease	_____	_____	Flashes	_____	_____
Itching eye's	_____	_____	Watery eye's	_____	_____
Burning eye's	_____	_____	Pregnant	_____	_____

Other Medical or eye Conditions: _____

INSURANCE

All medical/vision insurance must be pre-approved prior to your exam. By giving us your insurance information, you are giving us permission to go through whichever one of your insurances that provides you the most benefits. If we are unable to verify coverage, all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits, or are eligible for less than full coverage, you agree to be financially responsible for any unpaid balance.

Medical Insurance: _____ ID: _____ Group: _____

Primary Cardholder's Name: _____ Relationship: _____

Primary's Date of Birth: ____/____/____ Primary's Social Security Number: ____-____-____

Vision Insurance: _____ ID: _____ Group: _____

Primary Cardholder's Name: _____ Relationship: _____

Primary's Date of Birth: ____/____/____ Primary's Social Security Number: ____-____-____

Contact Lens History (circle all that apply): Gas Permeable / Soft / Disposable / Monovision / Bifocal / Toric

Contact Lens Brand: _____ Solutions: Optifree / Biotrue / Other: _____

I assume all risk and responsibilities of wearing and maintaining my contact lenses. I will return for all follow-up visits. If for any reason I fail to follow the recommended wear and care instructions, I agree to accept full responsibility for any complications arising from noncompliance. Contact lens follow-ups, up to three times as deemed necessary by the doctor, must be completed within 90 days of initial visit. After that three-month period, any follow-ups will be subjected to a \$50 charge per visit.

Pupil Dilation (Additional \$30): A painless procedure in which eye drops are used to temporarily enlarge the pupils to allow a better view of the internal eye and aid in detecting various eye diseases and disorders. The dilation drops last about 4-6 hours. It temporarily impairs near vision and increases light sensitivity. Distance vision is generally not affected. **The doctor strongly recommends your eyes to be dilated for a thorough eye exam, especially if this is your first eye exam, you are a diabetic, have a history of glaucoma, cataracts, high blood pressure, have a high prescription, experience light flashes, floaters, or had trauma to the head or eye.**

I understand the importance of the dilated pupil exam and choose (PLEASE CIRCLE ONE BELOW):

- A) To be dilated today.
- B) No dilation. (I agree to assume all risk associated with failure to diagnose my eye condition due to lack of information, which may have been provided by this test.)

Visual Field Test (Additional \$20): This test helps detect many types of visual field loss caused by eye diseases like glaucoma, brain tumor, retinal tear, or optic nerve defect. This test does not require eye drops.

IF YOU CHOOSE BOTH PUPIL DILATION AND VISUAL FIELD TEST, YOU WILL GET A \$5 DISCOUNT (PLEASE CIRCLE ONE BELOW):

- A) Yes, I would like to have it done today.
- B) No, I decline.

ALL FEES ARE DUE AT TIME OF SERVICE AND ARE NON-REFUNDABLE.

I UNDERSTAND I HAVE 90 days from the date of the initial exam to have my glasses prescription rechecked without incurring additional charges. After 90 days, any glasses recheck will incur a \$40 charge. I acknowledge receipt of Eye Care 4 TX Notice of Privacy Practices. I have read and agreed to all the conditions on this page and authorize examination and treatment.

Signature of patient or responsible party (persons under 18 must have parent/guardian sign):

Signature: _____ Date: _____