

# 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 insurance 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 90 day period, any follow-ups will be subjected to a \$50 charge per visit.**

**RETINAL EVALUATION** allows the doctor to get a thorough view of the inside of the eye to diagnose eye diseases that can possibly lead to permanent vision loss like macular degeneration, glaucoma, and diabetic retinopathy. **A retinal evaluation is strongly recommended for all new patients, patients with a history of glaucoma, cataracts, high blood pressure, high prescription, diabetes, light flashes, floaters, or trauma to the head or eye.** There are **TWO OPTIONS**:

1. **Dilation (Additional \$30)**- A painless procedure in which eye drops are used to temporarily enlarge the pupils to allow the doctor a better view of the internal eye. Your NEAR vision will be blurry and you will be light sensitive for 4-6 hours.
2. **Retinal Imaging (Additional \$40)** – A photograph of your retina is taken. Your vision is NOT compromised. NO drops are involved. This procedure allows the doctor to document and review your retina with you over time.

I understand the importance of a retinal evaluation and choose **(PLEASE CIRCLE ONE)**:

- A) Retinal Imaging (additional \$40) -OR- Dilation (additional \$30)
- B) I decline both Retinal Evaluation tests above. (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 these tests.)

**VISUAL FIELD EVALUATION (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 THIS TEST ALONG WITH A RETINAL EVALUATION TEST ABOVE, YOU WILL GET A \$5 DISCOUNT) (PLEASE CIRCLE ONE BELOW):**

- A) Yes, I would like to have the visual field evaluation done today.
- B) No, I decline the visual field evaluation.

## **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 of 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: \_\_\_\_\_