concept
EYECARE

WELCOME TO OUR OFFICE

Please fill out the form accurately and completely.

PATIENT INFORMATION

Last name_____ First name _____ Middle Name_____

Preferred name_____ Birth date _____Age _____ Sex ☐ M ☐ F Race_____

Address _____ City _____ State _____ Zip _____

Preferred phone number _____ (Cell/Work/Home) Secondary number _____ (C/W/H)

Patient SSN _____ Email _____

Communication preference: ☐ Phone ☐ E-mail ☐ Text

Occupation _____ Employer _____

Check Appropriate Box: □ Single □ Married □ Divorced □ Separated □ Widowed □ Other

□ Minor – Guardian's name: _____

INSURANCE INFORMATION

Vision insurance _____ Group number _____ ID number _____

Medical insurance _____Group number _____ ID number _____

Subscriber name _____Relationship to patient _____ Subscriber birth date _____

Subscriber's information (if different from patient):

Address _____ City _____ State _____ Zip _____

Phone number _____ Subscriber SSN / ID number _____

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above plan(s) and assign directly to Concept Eyecare, PLLC all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by the insurance and that professional fees are non-refundable**. I understand that my vision and/or health insurance coverage is a contract between myself and my insurance company and that it is ultimately my responsibility as the patient to understand my insurance coverage as well as handle any charges my plan does not cover.

Patient/Guardian Signature _____ Date _____

MEDICAL HISTORY

Reason for today's visit:

_____

Last eye exam _____ Results:_____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are they?_____

Do you wear contacts? ☐ Yes ☐ No If yes, what brand and power?_____

Last physical exam? _____Primary care physician name and number: _____

Are you currently experiencing? (Please check all that apply)

☐ Double vision	☐ Redness	☐ Itching	☐ Flashes of light	☐ Dry eye
☐ Blurred vision	☐ Tearing	☐ Burning	☐ Floaters	☐ Light sensitivity

Have you or any of your immediate family members been diagnosed with any of the following:
(Please check all that apply)

	Self	Relative		Self	Relative
Amblyopia / lazy eye	☐	☐	Heart disease: _____	☐	☐
Blindness	☐	☐	Cancer:_____	☐	☐
Crossed eyes	☐	☐	Lung disease:_____	☐	☐
Cataracts	☐	☐	Neurological (MS, stroke, etc):_____	☐	☐
Glaucoma	☐	☐	Autoimmune (Lupus, RA, etc.):_____	☐	☐
Macular degeneration	☐	☐	Psychiatric (anxiety, depression, etc):_____	☐	☐
Retinal disease	☐	☐	Hematologic (anemia, bleeding, etc.):_____	☐	☐
Eye injury/infection	☐	☐	Infectious (HIV, etc.) _____	☐	☐
Diabetes	☐	☐	Dyslipidemia (cholesterol, triglyceride):_____	☐	☐
High blood pressure	☐	☐	Other (please list below):		
Thyroid	☐	☐	_____		
Kidney disease	☐	☐	_____		

Please list all **major eye surgeries** you have had (include dates):

_____

Please list other **medical surgeries** you have had (include dates):

_____

Please list all **medications** you take, including eye drops, contraceptives, and over-the-counter medications:

_____

Please list any **allergies** you have (medications and other) _____

_____

MEDICAL HISTORY (CONTINUED)

Do you use tobacco? ☐ Yes ☐ No If yes, amount and for how long _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, type / amount / for how long _____

Are you currently pregnant or nursing? ☐ Yes ☐ No

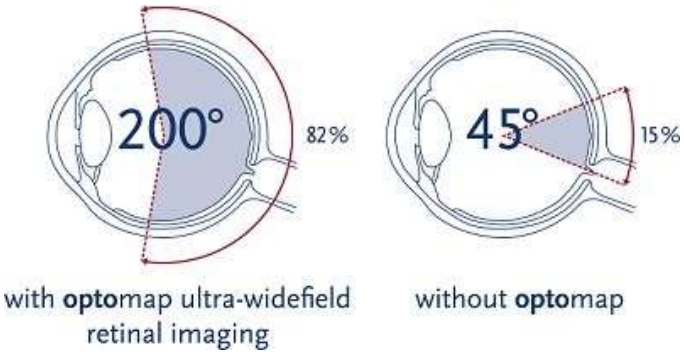
RECOMMENDED TESTS

WHAT IS DILATION/OPTOMAP?

These procedures allow for the thorough examination of the internal health of your eyes and signs of other diseases (for example hypertension, diabetes, etc.). Without one of these procedures, your eye doctor only sees about 30% or less of the eye's interior surface, leaving potential problems undetected. Early detection is crucial to saving your sight, as many early eye diseases are asymptomatic.

PUPIL DILATION: is the process of administering eye drops in order to enlarge the pupils temporarily. This allows an eye doctor to have greater view of the inside of the eye. It helps the detection and diagnosis of certain eye diseases and conditions such as: diabetes, eye tumors, high blood pressure, infectious diseases, macular degeneration, retinal detachment, etc. It will cause your vision to be blurred, primarily up close, as well as light sensitive for approximately 3-5 hours. This procedure will add an additional 30 minutes to your eye examination.

OPTOMAP (OPTOS) RETINAL IMAGING: is a retinal image taken of the back of the eye. It provides an ultra-widefield 200 degree retinal imaging. This allows for the similar evaluation as the dilation but WITHOUT the inconvenient side effects of dilation drops and only takes a few minutes. These images are saved and able to be compared year after year, making it easy to see changes that may occur. It gives the doctors an immediate view of the retina without dilation. NOTE: in some cases, dilation will also be medically indicated.



DECISION TIME: please check one of the following

☐ Yes, I would like the DILATION. **There is NO additional charge.**

☐ Yes, I would like the (NO DROPS) OPTOMAP imaging. **The fee is $39.**

☐ I would like to discuss further with the doctor

iWELLNESS EXAM - is a high-resolution cross-sectional scan, which provides detailed images beneath the surface of the retina that otherwise cannot be visible (like an MRI of the eye). The scan assists with early detection of retinal abnormalities and vision threatening pathologies before such diseases are visible through a traditional eye exam. The iWellness exam is recommended annually. Information gathered from this exam will assist our doctors to monitor subtle changes or defects of the retina occurring over time.

DECISION TIME: please check one of the following

☐ Yes, I would like to have the iWellness exam today. **The fee is $30.**

☐ No, I am declining the the iWellness exam

FINANCIAL RESPONSIBILITY

- I understand that all professional fees are due and payable at the time service and are non-refundable. If a courtesy spectacle recheck is needed, it must be done within 2 months from your initial exam. Any contact lens follow-up will be covered by the contact lens fit/evaluation fee, but it must be done within 2 months of your initial exam to avoid any late follow-up fees.
- Glasses returns are only accepted within 15 days (including non-business days) from the date of dispense.
- Returns must be free of defect & damage. At our discretion, we may deny returns of damaged materials.
- **Prescription lenses are considered custom orders. We will do our best to resolve any issues you may have with your spectacles. Returns are subject to a restocking fee of 15% of the cost of the frame plus lenses before insurance and discounts, if any.**
- If glasses are not picked up or paid in full by 60 days after your glasses are ready, any deposits and/or insurance benefits will be forfeited, and your order will be cancelled.
- If your contact lens prescription have changed, we will gladly exchange contact lenses purchased from our office. We can only accept unopened and unmarked contact lens boxes and the exchange must be within 6 months from the date of purchase.
- Contact lens returns are only accepted within 30 days upon pick up. Boxes must be unopened and unmarked.
- We ask that patients cancel appointments with a minimum of 24 hours advance notice in order to avoid missed appointment/same day cancellation fee of $25.
- We utilize Patient Health Portal to upload necessary documents. Once your glasses or contact lens prescription is finalized, it will be uploaded to your patient portal. Once uploaded, you will get a notification via e-mail.

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I acknowledge that I have read and understand the Notice of Privacy Practices. I also consent to the use and disclosure of my information to only carry out treatments, payment activities, and submission of insurances.

I have the right to allow the following person(s) access to my information and communicate with the staff at Concept Eyecare on my behalf (Example: your spouse or a parent)

1)_____ Relationship_____

2)_____ Relationship_____

I have read and understand insurance assignment of benefits, privacy policy, and financial/office policies. I acknowledge that my spectacle and contact lens prescription will be available on the patient portal, and I understand how to access the Patient Health Portal with Concept Eyecare. As a patient, I have the right to voice any concern regarding any of the above statements. By signing below, I understood and acknowledge Concept Eyecare's policies.

_____	_____
Signature of patient or parent/guardian	Date
_____	_____
Print	Date