WELCOME TO FOCUS EYE CARE, INC.

Name _____ Gender M F Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Date of Birth _____ Age _____ Marital Status _____ Referred By _____

Employer _____ Occupation _____ Email _____@_____

I have been provided with a copy of the HIPPA privacy policy to read _____
(Please see last page) Signed (Parent/Guardian if the patient is under 18) Date

INSURANCE INFORMATION

Plan Name _____ Group _____

Insured Name _____ Relationship to Patient ☐Self ☐ Spouse ☐ Child Patient SS# _____

Insured ID# _____ Insured DOB _____ Insured SS# _____

OCULAR AND MEDICAL HISTORY

What is your reason for today's exam? _____

Age of Present Glasses _____ Age of Sunglasses _____Date of last Eye Exam ____/____/_____From Dr. _____

Do you or any of your blood relatives (I.E. grandparents. Parents, brother or sister) have any of these conditions?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
Diabetes	☐	☐	☐	Glaucoma	☐	☐	☐	Do you see double?	☐	☐
High Blood Pressure	☐	☐	☐	Cataracts	☐	☐	☐	Frequent Headaches?	☐	☐
Thyroid Problems	☐	☐	☐	Retinal Disease	☐	☐	☐	Bright lights bother you?	☐	☐
Heart Disease	☐	☐	☐	Eye Surgery	☐	☐	☐	Are you pregnant?	☐	☐
Asthma	☐	☐	☐	Eye Injury	☐	☐	☐	Eyes been dilated? ☐☐Yr___		
Cancer	☐	☐	☐	Other _____	☐	☐	☐	Primary Care Dr. _____		

Are you taking any eyedrops (Prescription or over the counter)? Please List._____

_____

Are you taking any other medications (Prescription or over the counter)? Please list._____

_____

Do you have any allergies, medication or other? If yes, please explain. _____

_____

CONTACT LENS INFORMATION

Do you wear contacts now? Yes ☐ No ☐If yes, what type? _____

Have you worn contact lenses? Yes ☐ No ☐If yes, what type? _____

Are you interested in new contact lenses? Yes ☐ N0 ☐If yes,what type?Daily disposable, Gas Perm, Specialty, etc. _____

****Contact Fitting Fees: Single Vision Fit $34, Astigmatism/Mono Vision Fit $67, Multifocal Fit $94, and Specialty/Hybrid Fit $110****
CONTACT FITTINGS MUST BE PERFORMED YEARLY PER THE GEORGIA LAW O.C.G.A. § 31-12-12 (2005)TO ENSURE THE EYE IS HEALTHY ENOUGH FOR CONTINUED CONTACT LENS WEAR. PLEASE ASK YOUR PHYSICIAN OR OPTOMETRIC TECH IF YOU HAVE ANY QUESTIONS.

*******ALL FEES ARE ADDITIONAL TO THE ROUTINE EXAM FEE OF $76*******

Additional recommended Procedures and Pricing:

PUPIL DILATION: No charge for this procedure.
The doctor may need to use drops to dilate your eyes. Do you give permission for these drops to be used?
☐ I do ☐ I do not give permission for diagnostic drops to be instilled in my eyes.

RETINAL PHOTO: (Vision Insurance will not cover this test). *****The fee is $18.00 per eye.($36 for both.)**
We have a retinal camera that takes a photograph of the inside of your eye. This allows the doctor to have a picture to evaluate today and to compare with at future visits. Do you give permission for this test?
☐I do ☐ I do not give permission for retinal photos.

FIELDS TESTING: (Vision insurance will not cover this test). *****The screening fee is $18.00.**
We have a computerized state of the art instrument that can assist the Doctor in detecting many medical and ocular diseased which include: Headaches, Stroke, Glaucoma, Retinal Detachment, Brain Tumors, High Blood Pressure, and Diabetes. This screening is quick, painless and does not require dilation**.**
☐I do ☐ I do not give my permission for a visual field test.

*VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.*If you are not eligible for insurance benefits, or are eligible for less than full coverage, your signature below indicates that you authorize payment of insurance benefits to your provider on your behalf and you agree to be financially responsible for any balance that is not paid by your insurance plan.
PROFESSIONAL FEES AND COLOR CONTACTS, DAILY DISPOSABLE CONTACTS OR OPEN/DAMAGED CONTACT LENS BOXES ARE NOT REFUNDABLE OR EXCHANGEABLE.
You have 90 days from your exam date to have a prescription adjusted at no cost if error on our part; otherwise a $40 refraction may be charged.

Signed: _____ Date: _____