WELCOME TO FOCUS EYE CARE!

Name ____ Gender M F Date ________________________________

Address ____ City ____________________ State ______ Zip ________________

Home Phone (_______)_______________ Cell Phone (_______)__________________ Do you give permission to leave a voicemail? Y/ N

Date of Birth __________________ Age ________ Marital Status ______________ Referred By ________________________

Employer ____________________ Occupation ________________ Email ____

I have been provided with a copy of the HIPAA privacy policy to read **Signed:____
(Please see last page) **Parent/Guardian must sign if the patient is under 18** **Date**

INSURANCE INFORMATION

Plan Name ____ Primary 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 eye drops (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 ☐ No ☐ If yes, what type? Daily disposable, Gas Perm, Specialty, etc.________________

Contact Fitting Fees: Single Vision/Standard $38, Astigmatism/Mono Vision $72, Multifocal $98, and Specialty/Hybrid $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 *******

Additional Recommended Procedures and Pricing:

PUPIL DILATION: No charge for this procedure.
Dilation gives the doctor a better view by allowing more light into the eyes.

☐ I do ☐ I do not give permission for pupil dilation at this time.

RETINAL PHOTO: (***Vision Insurance will not cover this test).*** *****The fee is $19.00 per eye. ($38 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 compare with at future visits. This photograph can assist the Doctor in detecting many medical and ocular diseases which include: Macular Degeneration, Diabetes, Stroke, Retinal Detachment, High Blood Pressure, and High Cholesterol. This screening is quick, painless, and does not require dilation.

☐I do ☐ I do not give permission to do retinal photos at this time.

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 diseases which include: Multiple Sclerosis, Brain Tumors, Glaucoma, Headaches, and Retinal Detachment. This screening is quick, painless, and does not require dilation.

☐I do ☐ I do not give my permission for a visual field test at this time.

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, (i.e., deductible, out of network fees, etc.)
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 fee may be charged.

Signed: ____ Date: ________________________
Must be signed by Parent/Guardian if the patient is under 18