Welcome to Atlanta Eye Care

Date ___/___/___

Patient name _____DOB ___/___/___ Age ___ Sex M / F (circle one)
Address _____City_____
State_____ Zip_____ Home/Work (_____)_____
Cell (_____)_____ Email_____
Marital Status_____ SSN_____-_____-_____
Employer_____Occupation_____
Vision Insurance Company_____Medical Insurance Company_____
Relationship to Insured_____ Insured's Name_____ DOB_____/____/_____
Insured's SSN_____-_____-_____

HOW DID YOU HEAR ABOUT US? _____

HEALTH HISTORY

1. Reason for today's visit_____
2. Date of last exam_____Name of last eye doctor_____
3. Do you or anyone in your immediate family have a history of the following? **YES**____ **NO**____
If **YES**, please list relationship. Diabetes_____ High Blood Pressure_____ Heart Condition_____
Thyroid_____ Cataracts_____ Glaucoma_____ Macular Degeneration_____
Blindness_____ Retinal Detachment_____ Turned or lazy eye_____
Other (please list)_____
4. Do any of the following conditions apply to you? (check all that apply)
_____Headaches/Migraines _____Sinus Trouble _____Pregnant _____Recently had a child
Other Allergies (please list)_____
Drug Allergies (Please List)_____
5. Please list all current medications:
_____
_____
6a. Have you ever had any of the following conditions involving your eyes? **YES**_____ **NO**_____
If **YES**, please **CIRCLE**: Eye strain / Poor near vision / Double vision / Severe pain / Poor distance vision / Light sensitivity / Floaters or Spots / Burning / Itching / Watering or Tearing
B. Have you had a history of:
Eye Injury: Date_____ Type_____ Eye_____
Eye surgery: Date_____ Type_____ Eye_____
Medical treatment: _____
Eye infection/disease: _____ Eye_____
7. Do you currently wear glasses? **NO**_____ **YES**_____
Circle which type: Reading only, Distance only, Progressive (no line), or Bifocal (lined)
8. Have you worn contact lenses before? **NO**_____ **YES**_____ Brand_____

REVIEW OF SYSTEMS

12. What is your general health condition? _____
13. Do you have any problems with any of these systems? **YES**_____ **NO**_____ (circle all that apply)
Gastrointestinal / Nervous / Respiratory / Musculoskeletal / Genitourinary / Mental / Blood or Lymph
Ear/nose/throat / Cardiovascular / Skin / Endocrine (Thyroid/Diabetes) / Allergic or Immunologic
14. Do you use cigarettes/tobacco?_____ Alcohol?_____
15. Name of family doctor_____ Last visit_____

DILATION

Our standard care is to dilate every patient at each comprehensive exam. This allows the doctor to obtain a superior view of the health of the retina and the associated systemic issues. It is included with your complete exam at no extra charge. It is your option to decline this procedure. If you have questions, please ask the front desk or doctor during your exam. Please check yes if you would like to be dilated or no if you would like to decline

Yes _____

No _____

FOR CONTACT LENS WEARERS (IF YOU ARE NOT A CONTACT WEARER, PLEASE DECLINE)

The state of Georgia requires that a contact lens evaluation be done every 12 months to update your contact lens prescription in order to maintain the health of the eye. This applies to all patients even though you may have worn contact lenses in the past or even if the prescription does not change. **Contact lens evaluation fees are not included as part of your comprehensive exam charge, and are generally $50-75.** Your evaluation fee covers the first 90 days of follow-up care.

I **DO** want a contact lens prescription: _____

I **DO NOT** want a contact lens prescription/ I **DO NOT** wear contacts: _____

Patients who are being prescribed contacts lenses as a **first-time wearer will be taught how to put the lenses in and take them out by a technician or optician. This is required, as lenses are a medical device being placed directly on the eye. **The fee for this lesson is $25.**

RETINAL PHOTOGRAPHY

We are offering the newest technology in retinal photography using **opto**map. With this photography, we are able to non-invasively capture an instantaneous, ultra-wide digital image of the retina, revealing important information for the comprehensive evaluation of your systemic and ocular health. An **opto**map assists in the diagnosis of eye conditions and allows the doctor to begin treatment that may actually prevent vision loss. Retinal photography is important in the early detection and diagnosis of eye problems such as retinal detachment and tears, diabetic retinopathy, age-related macular degeneration, changes due to glaucoma, hypertensive retinopathy, diabetes, hypertension, and certain Cancers. These digital images are especially important for patients with a person or family history of high blood Pressure, diabetes, retinal disease, strong eyeglass prescription, high pressure in the eye, or glaucoma.

Retinal photography is not covered by vision insurances and the fee is $39.00. Please check Yes or No.

Yes _____

No _____

LASIK SURGERY

Yes I would like to discuss the possibility of Lasik surgery _____

No I would not like to discuss Lasik surgery _____

ABOUT YOUR INSURANCE

There are two types of health insurance that will help you pay for your eye care service and optical products. You may have both types and Atlanta Eye Care accepts most insurance plans in both categories: 1. Vision plans (VSP, EyeMed, and other) and 2. Medical insurance (BCBS, Aetna, Medicare and other) ** VISION plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems) ** MEDICAL insurance must be used for medical eye care (the diagnosis, management or treatment of eye health problems) only. If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expenses. If some fees are not paid by your insurance, such as deductibles, co-pays or non-covered services as allowed by the insurance contract, it becomes your responsibility and we will send you an invoice for prompt payment. Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it for future services.

_____ I have read and accept these policies (please initial)

It is your responsibility to read and understand your own insurance policy. Certain services and procedures may or may not be covered by your insurance. It is your responsibility to contact your insurance company to find out whether Drs. Arey, Alexander, Walker, Lundy, Moon, or Volingavage are participating providers. In closing, insurance information must be presented at the time of service. We CANNOT BACK DATE SERVICES. This office is HIPAA compliant. A copy of The Privacy Information Practice is available at your request.

Signature _____ **Date** _____