DEMOGRAPHICS:

First Name: ____________________ Last Name: ____________________

Address: ______________________________ DOB ____ / ____ / ____
(STREET) (CITY) (STATE) (ZIP)

CONTACT INFORMATION:
PLEASE CHECK PREFERRED

❏ HOME (______) ______ - ______ ❏ WORK (______) ______ - ______

❏ CEL (______) ______ - ______ ❏ E-MAIL ____________________

INSURANCE INFORMATION: ❏ LIST, ____________________ ❏ NONE, SELF PAY

REASON FOR VISIT: please print

CONTACT LENS HISTORY: Are you interested in a contact lens exam today? ☐ YES ☐ NO

IF YOU ARE CURRENTLY WEARING CONTACT LENSES PROVIDE THE FOLLOWING INFORMATION LENS TYPE: ☐ SOFT ☐ HARD ☐ HYBRID

LENS NAME: ____________________ RIGHT POWER: ____________________

☐ NOT SURE OF BRAND OR POWER LEFT POWER: ____________________

REVIEW OF SYSTEMS: PLEASE CIRCLE the condition(s) that apply to you.

❏ ***NO PROBLEMS***	*OTHER*	____________				*GI*	Celiac Disease	Acid Reflux	Colitis	Chron's	Ulcer
BODY	Cancer	Fatigue Syndrome	Developmental Disability			***GU***	Nursing	Prostate Hypertrophy	Herpes	STD	Pregnant
ENT	Sinusitis	Laryngitis	Dry Mouth	Hearing Loss		***MUSC SKELETAL***	Osteoarthritis	Muscular Dystrophy	Gout	Ankylosys Spondylitis	Fibromyalgia
NEURO	Cerebral Palsy	Multiple Sclerosis	Stroke/CVA	Epilepsy	Migraines	***SKIN***	Rosacea	Eczema	Cold Sores	Psoriasis	Herpes Zoster
PSYCH	Depression	Bipolar	Attention Deficit	Anxiety Disorder		***ENDO***	Thyroid Dysfunction	Diabetes Type 2	Diabetes Type 1	Hormonal Dysfunction	
CARDIO	Vascular Disease	Stroke/CVA	Hypertension	Heart Failure	Heart Disease	***BLOOD***	Anemia	High Cholesterol	Large Volume Blood Loss		
RESP	Emphysema	Chronic Obstruction	Bronchitis	Sleep Apnea	Asthma	***ALLERGY***	Lupus	Drug Allergies	Sjogren's	Rheumatoid Arthritis	Environmental Allergies

MEDICATIONS: ❏ NONE List any prescription or non-prescription medications (and strength) that you are currently taking OR Select the therapy that applies.

❏ Acid Reflux Medication	❏ Asthma Medication	❏ Cholesterol	❏ Eyedrop - Artificial Tears	❏ Hormone Replacement	❏ Topicals (creams/ointments)
❏ Allergy Medication	❏ Baby Aspirin	❏ Depression Therapy	❏ Eyedrop - Glaucoma	❏ Migraine Therapy	❏ Vitamins
❏ Antibiotic Therapy	❏ Birth Control	❏ Diabetes Medication	❏ Eyedrop - OTC Allergy	❏ Pain Medication	____________
❏ Anti-viral Therapy	❏ Blood Thinners	❏ Diabetic Insulin	❏ Gout Medication	❏ Prostate Medication	____________
❏ Anxiety Medication	❏ Chemotherapy	❏ Eyedrop - Antibiotic	❏ High Blood Pressure	❏ Thyroid Medication	____________

ALLERGIES: ❏ NONE List any medication allergies that you may suffer from OR Select the allergy group that applies.

MEDICATION ❏ Sulfa Drugs ____________ **OTHER** ❏ Bee stings ❏ Food: Nuts Allergy ____________

❏ Penicillins ____________ ❏ Environmental: Seasonal ❏ LATEX Sensitivity ____________

PAST OCULAR HISTORY: Circle any applicable eye conditions.

❏ ***NONE***	Strabismus	Retinal Hole	Keratoconus	Amblyopia
Cataracts	Glaucoma Suspect	Eye Patching	Surgery	Retinal Detachment
Glaucoma	Injury	Macular Degeneration	Other: ____________	

FAMILY HISTORY: Do any of your family members suffer from any of the following?

MEDICAL	Diabetes	Cancer	High blood Pressure	Other: ____________	❏ ***NONE***
OCULAR	Glaucoma	Amblyopia	Macular Degeneration	Other: ____________	❏ ***NONE***

SOCIAL HISTORY:

Do you drink? ☐ NO ☐ YES Amount ____________

Do you smoke? ☐ NO ☐ YES Amount ____________

Smoking Status: Never Smoker / Former Smoker / Current Occasional Smoker / Current Every Day Smoker

Hobbies ____________________

Please carefully read and initial all office policies on the following page

OCULAR HEALTH EVALUATION

This office will make every effort to perform a complete retinal evaluation with each comprehensive eye examination.
The internal ocular evaluation is an important component of a full evaluation since many eye problems can develop without symptoms. To accomplish a full internal health assessment, our doctor highly recommend that a retinal scan be performed during the preliminary testing. This procedure will allow the doctor to establish a baseline with a digital record of the internal structures of the eyes. In certain cases, a dilation exam must still be performed in addition to the Retinal Pictures or vice versa.

Retinal Pictures The camera is a specialized digital scanner that takes images of posterior structures of the internal eye. The procedure is very simple, painless and it only takes a few seconds to perform with no side effects. This procedure is recommended to be performed yearly and is not covered by insurance plans. The cost for the photograph is **$40**.

Pupil Dilation This procedure is included as part of your comprehensive eye exam and is essential to establish eye health. It normally **takes 20-25 minutes** after applying eye drops to achieve full pupil dilation. Be advised that you may experience blurred vision when reading or looking-off in the distance and increased light sensitivity for **approximately 4-6 hours**. If today is not a convenient time for you and choose to decline this test today, it can be rescheduled for a more convenient time if necessary but additional charges will apply.
By initialing this form, **I am acknowledging the importance of the eye health assessment and consent to the photo and pupil dilation** INITIAL ______

CONTACT LENS FITTING POLICY

Contact lenses are medical devices and State law prohibits dispensing contact lenses without a valid prescription or after one year from the original date of the contact lens evaluation. Disposable trial lenses are for fitting purposes only and will be dispensed at the initial fitting as part of the evaluation. Contact lens fittings are priced according lens type, modality and use. The contact lens fitting prices are:

Soft Standard $80	Soft Astigmatism $100	Soft Monovision $130	Soft Multifocal $130
Hybrid Standard $115	Hybrid Multifocal $140	Hybrid Keratoconus $300	
Gas Permeable Standard $120	Gas Permeable Premium $150		

A contact lens evaluation will be performed annually to renew the contact lens prescription. The fitting fee includes up to **two follow-up visits within a 30 day** period from the initial evaluation regardless of lens type or modality. We will schedule your follow-up appointment when it is most convenient to you. However, it is the patient's responsibility to make sure that the follow-up visit is completed within the 30 day time-period. If one fails to keep or schedule follow-up visits during the 30 day time-period, additional office visit charges will apply depending on the time period that has elapsed since the initial visit.
Contact lens prescriptions will be released to the patient after the trial or follow-up period is successfully completed. If a patient requires multiple contact lens prescriptions, fittings or evaluations, additional charges will apply. There will be a $45 contact lens fee per visit if more visits are needed or if its been more than 30 days since the initial fitting. But if it exceeds more 3 months but less then 6 months, the doctor recommends that we perform a refraction before proceeding. The refraction charge is $55 plus the corresponding fitting charge. If its been more than 6 months since the last eye examination, we recommend a complete evaluation to be performed.
One can choose to have a contact lens fitting at a later date for the difference in charge but it must be completed within a 3 month period of the comprehensive eye examination and refraction. If you are a new contact lens wearer, a 20 minutes training session is included as part of the evaluation. If additional trainings are needed the charge is $30 for a 20 minute session. **Payment for contact lens examinations, as with all other professional fees, is non-refundable.** INITIAL ______

CONTACT LENS MATERIALS RETURN POLICY

If you are dissatisfied for any reason with the purchased of your contact lens materials, the following policies will apply. Soft contact lens boxes can be returned for credit or refunded within 30 days of purchase as long as the boxes are unopened, undamaged and unmarked (except Frequency Toric). Gas permeable contact lenses, hybrid contact lenses and some soft contacts are made to order and can also be returned within 30 days period but a re-stocking fee is required depending on lens type and design and they must be returned with their original vial. Regardless of payment type used, an office check will be issued once the credit has been granted by distributor. INITIAL ______

SPECTACLES (FRAME/LENSES) POLICY

We will make every effort to verify your vision benefits (if applicable) to use towards the purchase of new frame and/or lenses. It is the patients responsibility to provide the adequate plan information at check-in. All sales of frame/lenses are final and adjustments and repairs are free of charge to our patients. If prescription verifications are needed, they will be honored at no charge within 30 days of refraction by appointment only. Only a credit towards future purchases will be honored. INITIAL ______

MEDICAL VISIT POLICY

Most vision insurance plans only cover routine yearly eye examinations but do not cover visits due to medical problems such as red eye, pink eye, corneal problems due to contact lens overwear, lesions or specialty evaluations. Therefore, medical visits will be filed under your medical insurance plan and deductibles will apply or an out of pocket fee expense if we do not file for your medical plan. Be advised that there may be certain specialty procedures that may not be covered such as pachymetry, gonioscopy, corneal topography and retinal or anterior photography. We will provide you with a detailed receipt if you choose to file with your medical insurance provider. Our office visit or medical visits are structured depending on their complexity and if additional **follow-up visits are needed then additional charges will apply.** INITIAL ______

INSURANCE SIGNATURE ON FILE

In most instances health insurances seldom cover eye exams, contact lens evaluations, contact lenses frames and glasses materials. Our office staff will make every effort to verify your benefits but **it is your responsibility to present the adequate insurance or vision plan information** at registration for verification before payment is collected.

INSURANCE INFORMATION: ❏ ______________________________ ❏ **NONE,** SELF PAY

If the insurance information or any vision plan is not presented or verified at the moment of registration, it will be my responsibility (or the guardian's if under 18 years of age) to self-file the claim with the insurance carrier. Therefore, no other discounts will be honored after services have been provided and payments have been received. the signature indicates that I agree to be financially responsible for my bill, understand the charges and am aware that **payment for professional services is non-refundable and glasses (frame/lenses) are non-refundable.**

INITIAL ______

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

The privacy act was established by the government to protect all your medical information and requires us to inform you that your medical information is confidential and we can only release it upon your request. By initialing you are agreeing that you have been made aware of the Notice of Privacy Practices for Marietta Vision Professionals and a copy of such can be provided upon request

INITIAL ______

I ____ have read and understand the presented office policies.
PATIENT'S FULL NAME AND/OR LEGAL GUARDIAN

SIGNATURE ____ **TODAY'S DATE** ______ / ______ / ______