

URBAN EYECARE

Dr. Stacie R. Lynn ♦ Dr. Chad T. Millsap

Patient Information and Medical History

To comply with medical record requirements, please complete the following information

Name _____	Today's date _____
Address _____	Date of birth _____ Age _____
City/State/Zip _____	Social Security # _____
Home Phone _____	Occupation _____
Work Phone _____ Cell _____	Employer _____
E-mail Address _____	Has any member of your household had an exam here? <input type="checkbox"/> yes <input type="checkbox"/> no
Marital Status: Married Single	Name _____
Name of spouse _____	How did you hear about our office? _____

What is your reason for today's eye exam? _____

<input type="checkbox"/> blur at distance	<input type="checkbox"/> headaches	<input type="checkbox"/> eye pain/discomfort	<input type="checkbox"/> trauma
<input type="checkbox"/> blur at near	<input type="checkbox"/> lazy eye	<input type="checkbox"/> itching	<input type="checkbox"/> red eyes
<input type="checkbox"/> broken glasses	<input type="checkbox"/> double vision	<input type="checkbox"/> flashes/spots	<input type="checkbox"/> tears/discharge
<input type="checkbox"/> contact lenses	<input type="checkbox"/> computer strain	<input type="checkbox"/> glaucoma	

Have you had an eye injury? Yes No If yes, explain _____

Have you had eye surgery? Yes No If yes, explain _____

How old are your glasses? _____

Are you interested in Contact Lenses? Yes No

If you are presently wearing contacts, what type? Hard Soft Disposable

Are you interested in Lasik surgery? Yes No

Are you interested in non-surgical vision correction? Yes No

Medical History

Do you have, or have you ever been treated for:

<input type="checkbox"/> diabetes	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> breathing problems	<input type="checkbox"/> arthritis/joint pain
<input type="checkbox"/> kidney/urinary	<input type="checkbox"/> depression/anxiety	<input type="checkbox"/> heart disease	<input type="checkbox"/> STD
<input type="checkbox"/> sinus/allergy	<input type="checkbox"/> stroke	<input type="checkbox"/> cancer	<input type="checkbox"/> skin condition
<input type="checkbox"/> stomach problems	<input type="checkbox"/> HIV	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> hearing loss

List any other medical conditions or surgeries: _____

Do you take any medications? Yes No If yes, list _____

Do you have any allergies? to medications? Yes No If yes, explain _____

Are you now pregnant and/or nursing? Yes No

Do you smoke? Yes No Do you drink alcohol? Yes No Do you have a history of drug use? Yes No

Please note any **Family history** (parent, grandparents, siblings, children (living or deceased)) for the following conditions:

<input type="checkbox"/> diabetes	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> heart disease	<input type="checkbox"/> arthritis
<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> retinal disease	<input type="checkbox"/> glaucoma	<input type="checkbox"/> macular degeneration
<input type="checkbox"/> blindness	<input type="checkbox"/> retinal detachment	<input type="checkbox"/> crossed/lazy eye	<input type="checkbox"/> other

Insurance Authorization

It is understood that the undersigned patient is eligible for benefits under this plan. Any quote of benefits is just an estimate provided to us by your insurance company. Payment will not be determined until the claim is received. Therefore, we are unable to guarantee any quote of benefits. In the event the patient is not eligible for coverage, has not met their deductible, insurance does not pay as expected, or the insurance company does not pay as expected, or the insurance company does not respond within 30 days of submitting the claim the patient or responsible party is ultimately responsible for any unpaid balance. There will be an additional fee of \$20.00 for any claim we have to turn over to our collection agency.

Patient Signature _____ Date of Service _____

Responsible Party _____ Date of Service _____

Signature _____ Date of Service _____

Contact Lens Policy

Most insurance companies cover a **Standard Eye Examination** only. This includes an assessment of the overall health of the eye and a prescription for glasses.

Examination for contact lenses is generally not covered by most insurance companies, and the following additional tests are necessary in order to determine a precise fit and proper contact lens prescription and to determine the eye's ability to safely wear contact lenses.

- Assessment and health of your cornea.
- Training of insertion and removal for new wearers.
- Keratometry – measures the central curve of the eye – needed to determine lens shape, size and power.
- Slit lamp biomicroscopy – microscopic evaluation of the front of the eye to rule out any conditions that could interfere with lens wear such as infection, allergies, inflammation or scarring.
- Tear volume and tear quality assessment.
- Examination with your present contact lenses.
- Determination of the contact lens prescription – different from the glasses prescription; the power needed in the lens to provide maximum vision.
- Contact lens design and analysis of the fit – evaluation of the lens on the eye to ensure a healthy fitting relationship; specifically, proper centration and movement when blinking.

There is an additional professional fee for the contact lens evaluation and fitting. The fee varies depending on the complexity of the prescription, the type of contact lens and the services necessary for the most optimal fit. The contact lens fitting fee includes all necessary follow up visits relating to the initial contact lens fitting for a 3 months period. Once the contact lens prescription is released to you, and if you choose to purchase the prescribed contact lenses from an outside source (**not** our office), you are then legally released from our care and there will be a charge for subsequent contact lens follow up visits.

Acknowledgement of the Above Contact Lens Policy and Fitting Fee

Patient Signature _____ Date of Service _____

Responsible Party _____ Date of Service _____

Signature _____ Date of Service _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have reviewed/received a copy of Urban Eyecare's Notice of Privacy Practices.

Print Name _____ Signature _____ Date _____