Welcome to Great Hills EYE CARE

Name: _____ Date of Birth: _____/_____/_____

Current Address:_____

City, State Zip _____ If Child (Guardian Name)_____

Email address: _____ Gender: M / F

Home Phone: _____ Wk Ph: _____Cell Ph: _____

Occupation: _____ Full Time/Part Time Place of Work: _____

Do you have family members that are seen here? If so, please list: _____

Eye and Medical History

Do you currently wear glasses? Y / N Do you currently wear contact lenses? Y / N

Are you here for: EYEGLASSES CONTACT LENSES RED EYE OTHER _____

How long since last exam _____

List current eye drops _____ Allergies to eye drops?_____

Have you had surgery on or around the eyes? Y / N Type _____ When_____

Past Eye History: Strabismus (Eye Turn) Amblyopia (Lazy Eye) Glaucoma Corneal injuries

Dry Eyes Iritis Retinal Detachment Macular Degeneration Retinal Disease Keratoconus Trauma

Family Eye History: Glaucoma Blindness Retinal Detachment Macular Degeneration NONE

MEDICAL HISTORY: Diabetes? Y / N For how long?_____ High Blood Pressure? Y / N

List ANY other medical conditions_____

List ANY current medications_____

Allergies to medications? Y / N List _____

NOTICE OF PRIVACY PRACTICES: This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Full copies are available by request in the office or available on our website. Sign, date, and print your name below indicating that you have been made aware of our Notice of Privacy Practices regarding HIPAA policies and offered a copy for your personal records.

Signature_____ Printed Name _____ Date:_____

(Please circle one: Patient or Guardian)

FINANCIAL RESPONSIBILITY AGREEMENT

- I am financially responsible for all charges incurred during eye exams or office visits to Great Hills Eye Care
All Charges are non-refundable. Payment is due at time of service.
- **If my insurance is billed and does not pay for ANY reason, I am responsible for full payment of remaining charges.**
- Routine exams for eyeglasses include one follow up appointment within 60 days of the initial examination. Any visits outside of the 60 days WILL INCUR an office visit charge.
- Certain Contact lens evaluations including toric, monovision, multifocal, and first-time wearers carry an additional fee Contact lens evaluations cover up to 2 follow-up visits and these must be completed within 60 days of the initial contact lens evaluation. Any visits outside of the 60 days WILL INCUR an office visit charge.
- Routine eye exams do not cover eye disease treatment or monitoring. Medical visits for red-eyes, dry eye/allergy treatment, foreign body removal (including contact lens and eyelash removal), and other medical services will be billed their corresponding office visit charges.

Signature_____ Date: _____

(Please circle one: Patient or Guardian)

PLEASE SEE OTHER SIDE

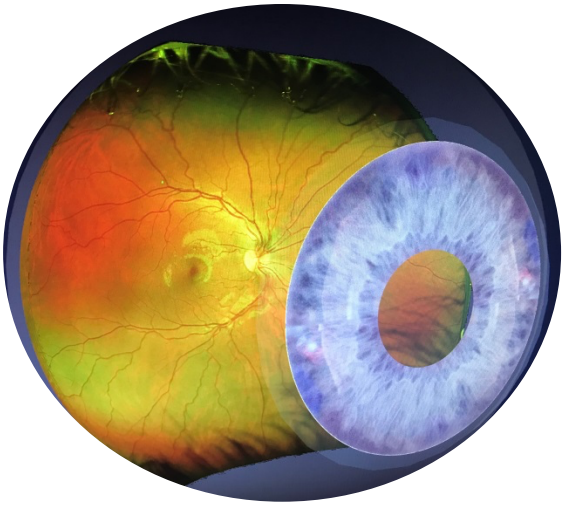
Optomap Retinal Screening

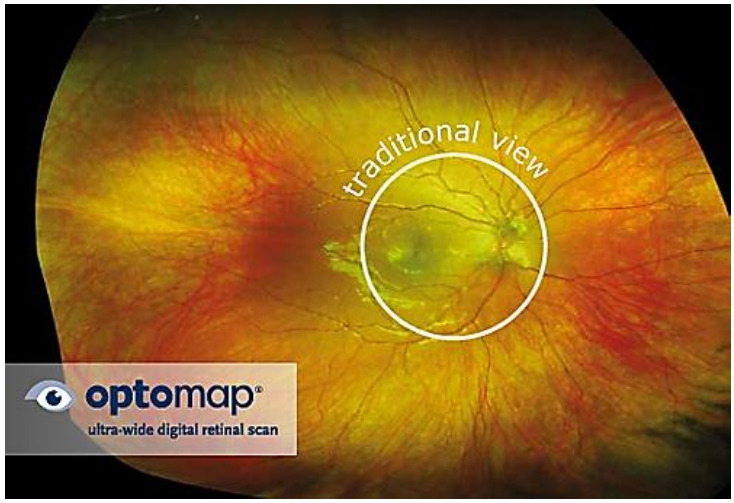
At Great Hills Eye Care, we believe that yearly retinal evaluations are critical in early diagnosis and monitoring of your eye health.
Therefore, we have acquired the Optomap Retinal Scanner as a way to capture wide angle images of the retina and detect early signs of eye disease that are may not be visible with the standard exam.
This advanced technology is doctor recommended on every patient as part of their yearly exam and carries a $39 charge.

Benefits of the Optomap Retinal Exam:

- Quick, easy, and comfortable – does NOT require dilation.
- A permanent record to compare and track potential eye disease
- In-depth view of the entire retina
- Educational tool for your doctor to discuss your eye health

I would like to have the Optomap performed today: Y / N





Visual Field Testing

- recommended if over 40, or family history of eye disease, or high prescription
- a more comprehensive test for early detection of Glaucoma and optic nerve disease
- $30 in addition to the regular exam

I would like to have the Visual Field Test performed today: Y / N

Dilation

If you choose not to have retinal imaging performed, or if certain medical conditions are present, you may require dilation. The drops cause light sensitivity and blurry vision for up to 4 - 6 hours.
- Dilation is $30 in addition to the regular eye exam.

I would like to be Dilated today: Y / N