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 _________________________

ARE YOU INTERESTED IN FINDING OUT IF YOU ARE A CANDIDATE FOR LASIK ? Yes No

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)

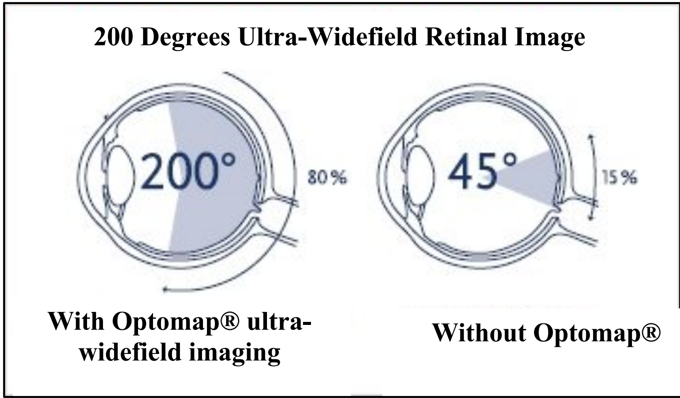
FINANCIAL RESPONSIBILITY AGREEMENT

- 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



We pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the Optomap® Retinal Exam on all of our patients during each annual eye exam.** The Optomap® retinal exam is a non-invasive no drop procedure that allows our doctors to capture 200 degrees ultra-widefield image of the back of your eye where potential vision threatening diseases can be found. **This includes diabetes, glaucoma, Age related Macular Degeneration, cancers, retinal tears, and cardiovascular issues.**

Also, you will not need to be dilated after the Optomap® image is captured.

As part of your pre-test work up, we will capture Optomap® images that you and your doctor will review together during your exam. The doctor will also answer any questions you may have about your eye health using the image. **There is a $39 co-pay for the Optomap® and the fee will be collected at the end of your exam with any additional insurance co-pays.**

I have read and understand this document:

Signature: ____Date: ____________________

Visual Field Testing

Some patients are more at risk for functional vision loss. To help uncover these early functional changes in your vision our doctors recommend the Visual Field Analyzer. It is a more comprehensive test for early detection of Glaucoma and optic nerve disease. There is a $30 co-pay for the Visual Field Analyzer.

Our doctors recommend this test for the following patients:

- over 40 years of age
- family history of eye disease
- high prescription

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