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? ☐ yes ☐ 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? _____

_____ blur at distance _____ headaches _____ eye pain/discomfort _____ trauma

_____ blur at near _____ lazy eye _____ itching _____ red eyes

_____ broken glasses _____ double vision _____ flashes/spots _____ tears/discharge

_____ contact lenses _____computer strain _____ 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:

_____ diabetes _____ high blood pressure _____ breathing problems _____arthritis/joint pain

_____ kidney/urinary _____ depression/anxiety _____ heart disease _____ STD

_____ sinus/allergy _____ stroke _____ cancer _____ skin condition

_____ stomach problems _____ HIV _____ thyroid problems _____ 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:

_____diabetes _____ high blood pressure _____ heart disease _____ arthritis

_____ sickle cell disease _____retinal disease _____ glaucoma _____ macular degeneration

_____blindness _____retinal detachment _____crossed/lazy eye _____ 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 _____