Dr Jan Eye Care Registration Form

Patient Information

Last, First, MI	Sex M / F	Date of Birth

Home Address

Phone ☐ Home ☐ Cell ☐ Work	E-mail

Referred By:	Occupation

Emergency Information

Name/Relationship to Patient:	Phone

Reason For Visit

Any issues with your eyes or vision? **YES** **NO**
Describe as needed:

When was your last eye exam?_____
Interested in LASIK? **YES** **NO**
What brand/type of Contact Lenses do you wear?_____

Review of Systems CIRCLE ALL THAT APPLY — Medication for Conditions – If none apply, check here ☐

developmental disorders, cancer, fatigue	NONE	
sinusitis, dry mouth, hearing loss, laryngitis	NONE	
multiple sclerosis, epilepsy, seizures, tumor, stroke, migraine	NONE	
depression, ADHD, anxiety, bipolar	NONE	
hypertension, stroke, congestive heart failure	NONE	
bronchitis, COPD, emphysema, asthma, cigarette smoker	NONE	
crohn's, colitis, ulcer, acid reflux, celiac	NONE	
kidney, prostate, STD, pregnant, nursing, herpes	NONE	
arthritis, fibromyalgia, muscular dystrophy, ankylosing spondylitis, gout	NONE	
eczema, rosacea, psoriasis, herpes, shingles	NONE	
diabetes type 1, diabetes type 2, thyroid, hormonal	NONE	
anemia, large volume blood loss, ulcer, high cholesterol	NONE	
drug/environmental allergies, rheumatoid, sjogren's, lupus	NONE	
Medication Allergies- NONE or Please list		

Past Ocular History CIRCLE ALL THAT APPLY

None	Glaucoma Suspect	Glaucoma	Cataract	Macular Degen	LASIK/PRK	Eye Turn (Strab)
Lazy Eye (Ambly)	Patching	Retinal Detach	Injury	Surgery	Keratoconus	Dry Eye

Social History CIRCLE ALL THAT APPLY

Do You Drink Alcohol? **YES** **NO** How much:	Do You Smoke? **YES** **NO** How much:	Hobbies

Family History – Note if your FATHER (F), MOTHER (M), BROTHER (Bro), SISTER (Sis), SON (S), or DAUGHTER (D)

Cancer	Diabetes	Hypertension	Thyroid Disease
Cataract	Macular Degeneration	Glaucoma	Keratoconus

CHECK ALL THAT APPLY

☐ **Eyeglass Exam $60**
(includes eyeglass prescription)

☐ **Contact Lens Evaluation $99-139**
(includes eyeglass prescription)

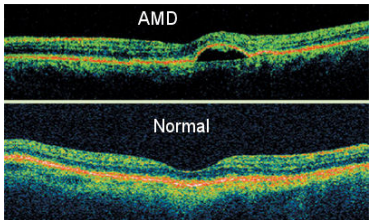
☐ **Contact Lens Training Class $20**
Required for First Time Contact Lens wearers

☐ **Optomap $35 ***
State of the art full retinal imaging evaluation to detect tears, detachments and more without eye drops

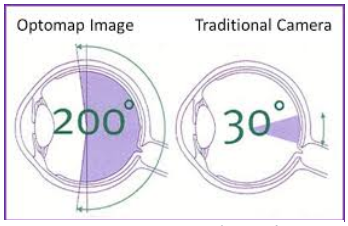
☐ **iWellness Exam $35 ***
Early Detection of diseases using scanning laser such as macular degeneration, glaucoma, diabetes, or hypertension

☐ **Medical Eye Exam $60-139**
Eye issues not related to glasses or contacts

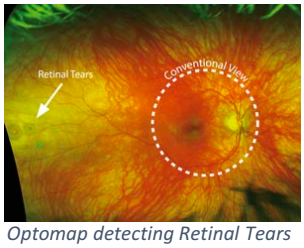
*The Optomap and iWellness are screeners for early detection of eye diseases. These tests typically are not covered by insurances.
Having both tests performed will be a value package at $50



iWellness Exam scanning the retinal layer detecting Macular Degeneration



Optomap view vs. Traditional view



Optomap detecting Retinal Tears in Periphery

Insurance Information

- Medical Insurance -

Primary	Secondary
Member's Name	Member's Name
Member's DOB:	Member's DOB:
ID#	ID#

- Vision Plan -

Plan	Last 4 digits of SSN

Signature on File

Financial Responsibility

The undersigned agrees to pay in full at the time of services, present insurance information for the filing of claims on that date of service, and to honor a payment agreement plan until the balance is paid in full. The undersigned further understands that the office will submit itemized statements to the insurance companies as a courtesy to the patients and that by his/her signature, the insurance companies are authorized to make the payment directly to the practice. The undersigned also understand the eligibility and benefits information from medical insurance or vision plans are only an estimated and are subject to change based on information received. The undersigned, however, does accept the ultimate responsibility for payment and services not covered by insurance companies for any eye services and testing performed. In the case the undersigned is unwilling to pay our office, we will send the statement to a Collection Agency. The undersigned understands all professional services and fees are nonrefundable.

Dilation

Dilation will enable your doctor to examine the posterior segment to better detect for eye diseases. Recommended for all patients, especially those with medical systemic conditions. I understand that if dilation exam is not performed, the Doctor may not be able to detect eye diseases that may be present on the back part of the eye. Common temporary effects of dilation are blurriness at near vision (4 hours) and increased sensitivity with bright lights (6 hours).

Authorization to Release Medical Information

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle. It is an essential part of an eye examination, but is NOT a covered benefit by Medicare or certain Medical insurances. Office fee for the refraction is collected in addition to the patient's copay at the time of the visit.

Notice of Privacy Practices

A "Notice of Privacy Practices" that describes how my protected health information is used and disclosed has been made available to me. I understand I may request a printed copy at any time.

PATIENT OR GUARDIAN SIGNATURE_____DATE_____