Welcome to Atlanta Eye Care Date _____/_____/______ (New)

Patient Name ____ DOB ____/____/____ Age ____ Sex M / F (circle one)

Address ____City_________________ State_______Z ip___________

Home/Work#(_____)_____________ Cell#(____)_______________ Email_______________________________________

Marital status __________ SSN# _____-___-______

Employer______________________________________ Occupation __________________________________

Vision Insurance Company __________________________ Medical Insurance Company __________________________

Relationship to Insured ___________________ Member Name ____

DOB ____/_____/______ Member SSN# _____/____/______ Member Employer _________________________________

Name of person responsible for account ___________________________How did you hear about our office __________________

HEALTH HISTORY

1. Reason for today's exam ____

2. Date of last exam ______________________ Name of last Eye Doctor _________________________________

3. Do you or anyone in your immediate family have a history of the following? **YES/NO** (circle one) **If YES, please list relationship**

☐ Diabetes________________ ☐ High Blood Pressure ______________ ☐ Heart condition ______________________

☐ Thyroid ________________ ☐ Cataracts______________ ☐ Glaucoma______________ ☐ Blindness ______________

☐ Macular Degeneration_______________ ☐ Retinal Detachment ________________ ☐ Turned or lazy eye_________

4. Do any of the following conditions apply to you? YES____ NO____ ☐ Headaches/Migraines ☐ Sinus Trouble

☐ Pregnant ☐ Recently had a child ☐ Seasonal Allergies ☐ Other Allergies (please list)______________________________

☐ Drug Allergies (Please list) ____

5. Please list ALL current medications, vitamins and supplements: ____
____

6. Have you ever had any of the following conditions involving your eyes? YES _____ NO _______

☐ Eye strain ☐ Poor near vision ☐ Poor distance vision ☐ Double vision ☐ Light sensitivity ☐ Severe pain

☐ Eye surgery Date ___________Type ____________________ ☐ Eye Injury Date___________ Type _________________

☐ Floaters/spots ☐ Burn/itch/water ☐ Eye infection/disease ☐ Medical treatment ______________________________

7. Do you currently wear glasses? YES ___ NO ____ Circle which type: Reading only, Distance only, Progressive or bifocal

8. Have you worn contact lenses before? YES _____ NO _____ BRAND: ____

9. Do you wish to continue wearing contact lenses? YES _______ NO _______

10. Do you work at a computer or video terminal? YES ________NO _______

11. What hobbies or sports do you enjoy? ____

REVIEW OF SYSTEMS

12. What is your general health condition? ___________________________

13. Do you have any problems with any of these systems? YES_____ NO_____ ☐ Gastrointestinal ☐ Nervous

☐ Respiratory ☐ Musculoskeletal ☐ Genitourinary ☐ Mental ☐ Blood/lymph ☐ Ear/nose/throat ☐ Cardiovascular

☐ Skin ☐ Endocrine (glands) ☐ Allergic/Immunologic ☐ Other _________________________________

14. Do you use cigarettes/tobacco? ____________ Previous tobacco use? ___________ Alcohol? ______________

15. Name of family Doctor_________________________________ Last visit _______________________________

For Contact Lens Wearers The state of Georgia requires that a contact lens evaluation be done every 12 months to update your contact lens prescription in order to maintain the health of the eye. This applies to all patients even though you may have worn

contact lenses in the past or even if the prescription does not change. Contact lens evaluation fees are not included as part of your comprehensive exam charge. Your contact lens evaluation fee covers the first 90 days of follow up care.
I have read and understand the contact lens evaluation fees: Initial _________________________

Dilation/Decline Waiver
Our standard care is to dilate every patient at each comprehensive exam. This allows the doctor to obtain a superior view of the health of the retina and the associated systemic issues. It is included with your complete exam at no extra charge. It is your option to decline this procedure. If you have questions, please ask the front desk or Doctor during your comprehensive exam.
Please check YES or NO __________ YES, I wish to accept your recommended standard for care of dilation
__________ NO, I wish to decline dilation today.

Retinal photography
We are now offering the newest technology in retinal photography using **opto**map. With this photography, we are able to non-invasively capture an instantaneous, ULTRA-widefield digital image of the retina, revealing important information for the comprehensive evaluation of your systemic and ocular health. An **opto**map retinal image enhances your clinical care, assists in the diagnosis of eye conditions and allows the doctor to begin treatment that may actually prevent vision loss.

Retinal photography is important in the early detection and diagnosis of eye problems such as retinal detachment and tears, diabetic retinopathy, age-related macular degeneration, changes due to glaucoma, hypertensive retinopathy, and diabetic retinopathy. These images can also indicate evidence of non-eye diseases such as diabetes, hypertension and certain cancers.

These digital images are especially important for patients with a personal or family history of high blood pressure, diabetes, retinal disease, headaches, strong eyeglass prescription, high pressure in the eye, or glaucoma.

This latest technology will allow your doctor a more significant and expansive view of your retina in one single image for evaluation of your ocular health. The fee for retinal photography is $39.00**.** **Please check YES or NO**

___________ YES, I wish to have baseline Retinal photography
___________ NO, I do not wish to have baseline Retinal photography

Lasik Surgery
__________ Yes, I would like to discuss having Lasik surgery
__________ No, I am not interested at this time

About your Insurance
There are two types of health insurance that will help you pay for your eye care service and optical products. You may have both types and Atlanta Eye Care accepts most insurance plans in both categories: 1. Vision plans (VSP, EyeMed and other) and 2. Medical insurance (BCBS, Aetna, Medicare and other)

** **VISION plans** only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems)

**** MEDICAL insurance** must be used for medical eye care (the diagnosis, management or treatment of eye health problems) only.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expenses.
If some fees are not paid by your insurance, such as deductibles, co-pays or non-covered services as allowed by the insurance contract, it becomes your responsibility and we will send you an invoice for prompt payment.
Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it for future services.
_____________ I have read and accept these policies. (please initial)

It is your responsibility to read and understand your own insurance policy. Certain services and procedures may or may not be covered by your insurance. It is your responsibility to contact your insurance company to find out whether Drs. Arey, Alexander, Walker, Hahn, Lundy or Volingavage are participating providers. In closing, Insurance information must be presented at the time of service. We CANNOT BACK DATE SERVICES. This office is HIPAA compliant. A copy of the Privacy Information Practice is available at your request.

Signature ____ Date ______________________________