

**Welcome to Atlanta Eye Care**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (Established)

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex M / F (circle one)  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
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 \_\_\_\_\_

**HEALTH HISTORY**

- Reason for today's exam \_\_\_\_\_
- 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 \_\_\_\_\_
- 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) \_\_\_\_\_
- Please list ALL current medications, vitamins and supplements: \_\_\_\_\_  
 \_\_\_\_\_
- 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 \_\_\_\_\_
- Do you use cigarettes/tobacco? \_\_\_\_\_ Previous tobacco use? \_\_\_\_\_ Alcohol? \_\_\_\_\_
- Name of family Doctor \_\_\_\_\_ Last visit \_\_\_\_\_
- Do you currently wear glasses? YES \_\_\_ NO \_\_\_ Circle which type: Reading only, Distance only, Progressive or bifocal
- Have you worn contact lenses before? YES \_\_\_ NO \_\_\_ BRAND: \_\_\_\_\_
- Do you wish to continue wearing contact lenses? YES \_\_\_ NO \_\_\_

**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 **optomap**. With this photography, we are able to non-invasively capture an instantaneous, ULTRA-widfield digital image of the retina, revealing important information for the comprehensive evaluation of your systemic and ocular health. An **optomap** 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 \_\_\_\_\_