Date:_____/_____/_____ Name:_____

Date of Birth:_____/_____/_____ Sex: ❑MALE ❑FEMALE ❑OTHER Salutation: ❑Mr. ❑Ms. ❑Mrs. ❑Dr.

Address:_____City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Family Physician: _____ Tobacco: ❑ YES (Pk/Day____) ❑ NO Alcohol: ❑ YES ❑ NO

MEDICATIONS *(including eye drops)*: ❑YES ❑NO (IF YES, PLEASE LIST) _____

ALLERGIES TO MEDICATIONS: ❑YES ❑NO (IF YES, PLEASE LIST) _____

Do you currently wear (please circle all that apply):	**Glasses**	**Contact Lens** (Brand:_____)	**None**
Do you want a prescription for (please circle):	**Glasses**	**Contact Lens** (Brand:_____)	**None**

Do you have **ANY EYE CONDITIONS**? ❑ NONE

❑Headaches* ❑Flashes of Light* ❑Floaters* ❑Double Vision* ❑Tearing/burning eyes ❑History of eye surgery

❑Glaucoma ❑Cataracts ❑Macular Degeneration ❑Blindness ❑Lazy eye/Eye turn ❑Retinal detachment ❑Itchy eyes

❑Other: _____

Are you pregnant or nursing? ❑YES ❑NO Have you been diagnosed with Diabetes? ❑YES ❑NO Hypertension? ❑YES ❑NO

Do you ***currently*** have any problems in the following areas? (IF YES, PLEASE PROVIDE EXPLANATION)

MEDICAL AND OCULAR HISTORY	YES	NO	EXPLANATION OF PROBLEM
CONSTITUTION/GENERAL (cancer, fatigue, etc.)			
EAR, NOSE, THROAT (sinusitis, hearing, etc.)			
NEUROLOGICAL (Migraines, epilepsy, etc.)			
PSYCHIATRIC (anxiety, depression, etc.)			
CARDIOVASCULAR (high blood pressure, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (stomach or intestines)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN (skin cancer, eczema, rosacea, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
ALLERGIES (seasonal, etc)			

Family Medical and Ocular History: ❑ UNKNOWN FOR ALL IMMEDIATE FAMILY MEMBERS

YES	NO	CONDITION	RELATIONSHIP (CIRCLE)					
		CANCER	Father	Mother	Brother	Sister	Son	Daughter
		DIABETES	Father	Mother	Brother	Sister	Son	Daughter
		HIGH BLOOD PRESSURE	Father	Mother	Brother	Sister	Son	Daughter
		HYPERTHYROID/HYPOTHYROID	Father	Mother	Brother	Sister	Son	Daughter
		CATARACTS	Father	Mother	Brother	Sister	Son	Daughter
		MACULAR DEGENERATION	Father	Mother	Brother	Sister	Son	Daughter
		GLAUCOMA	Father	Mother	Brother	Sister	Son	Daughter

********** OFFICE USE ONLY BELOW LINE **********

[ ]Self Pay(S-) [ ]EYEMED(92-) [ ]VSP(92-) [ ]MESVISION(S-) [ ]MEDICARE(92-) [ ]SPECTERA(92-) [ ]OTHER(92-) _____

Visual Field ($20) : _____ **CL($60-$75, I+R $35):**_____ **Exam Fee($89):**_____ **Refraction Fee ($45-only Medicare):**_____

Optomap ($45): _____ **Recall:** _____ **Reason For Recall:** _____

COMPREHENSIVE EYE

200 Mosaic Circle, Pooler, GA 31322

Vision insurance does not always cover every portion of your eye exam. Some of your eye care may have to be billed to your medical insurance depending on the extensiveness of the procedures or treatment pertaining to your individual case. This type of billing will occur if any part of your exam results in a diagnosis of or is a continuation of care for an eye disease. In the event that your exam falls into the category that allows for vision insurance, you will be responsible for any balance that is not covered by your vision insurance. In the event that your exam falls into the category of an eye disease that needs to be billed under medical insurance, you will incur the specialist co-pay along with the amount that goes towards your medical insurance deductible and any services not covered by your medical insurance.

Assignment of Medical Benefits and Responsibility of Non-Covered Services:
By signing this form, I acknowledge that I agree to the billing method for this eye exam that was explained above. I acknowledge the chosen benefit will be assigned to Comprehensive Eye. I also agree to the release of any of my information that may be required to secure payment of benefits, as well as the use of this signature on all insurance submissions. If the patient is a minor, I, as legal guardian, give consent for this exam and all future services rendered. It is my responsibility to know my insurance coverage. I agree to pay all co-pays on date of services. I agree to pay deductibles, and charges for non-covered services within 45 days of services rendered. I understand that, if some fees are not paid by my insurance, I am still financially responsible and will be billed for them.

Legal Guardian/Patient Signature_____ Date:_____/_____/_____

Notice of Privacy Practices:
I acknowledge that I have received and reviewed the laminated copy of the Comprehensive Eye Notice of Privacy Practices and understand that they may share my personal information with approved entities in order to facilitate my health care and the associated billing of insurance.

Legal Guardian/Patient Signature_____ Date:_____/_____/_____

Authorization to Release Information:
I hereby authorize providers at Comprehensive Eye to release my health information contained in the designated record set which Comprehensive Eye maintains on my behalf to the following:

Primary Care Physician:_____ Spouse:_____ Other: _____

Legal Guardian/Patient Signature_____ Date _____/____/_____

VISUAL FIELD SCREENING A critical part of comprehensive eye care is a Visual Field. We highly recommend this test which gives a computerized examination of your side (peripheral) vision. Many diseases revealed by a visual field are undetectable in an eye examination and may only be diagnosed with a visual field. Some of the diseases that a visual field may detect are GLAUCOMA, RETINAL DISEASE, BRAIN TUMORS, BLOOD DISORDERS and many other disorders relating to the eye and brain. Vision insurance does not cover the visual field screening. The fee for the visual field is $20.

_____I ACCEPT to have a screening visual field Patient Signature _____

_____I DECLINE to have a screening visual field Patient Signature _____

OPTOS OPTOMAP IMAGING REPLACES DILATION

We are excited to introduce Optos Optomap Imaging, our newest premium standard of care. Optomap imaging will replace dilation for your exam today unless deemed necessary by the doctor. As a non-invasive, instantaneous procedure, the Optomap is a highly recommended alternative to dilation. Optomap image capture reveals greater than 82% of the back of your eye. It can detect vision threatening diseases including but not limited to diabetes, glaucoma, cancer, retinal tears and cardiovascular issues that may be missed with dilation. THERE ARE ZERO SIDE EFFECTS OR LIGHT SENSITIVITY WITH OPTOMAP IMAGING NOR ANY DISCOMFORT. Optomap is prescribed annually with an insurance copay of $45. Comprehensive Eye honors this same copay if you do not have vision insurance. Your doctor will go over the results of your Optomap with you as view your images together during your exam and you may request images be emailed.

_____I ACCEPT to have optomap imaging Patient Signature _____

_____I DECLINE to have optomap imaging Patient Signature _____