Welcome to Our Office

The Doctors and staff are pleased to welcome you to U & M Family Eyecare P.C. Please take a few minutes to fill out this form as completely as you can. If you have any questions, it will be our pleasure to assist you. We look forward to working with you in maintaining your visual health.

Patient Name: _____ **Birth Date** _____ **Age** _____ ☐ **M** ☐ **F**

Mailing Address _____ **Apt #**_____ **City** _____ **State**_____ **Zip**_____

Home Phone _____ **Work #** _____ **Cell #** _____ **Text?** ☐ **Y** ☐ **N**

E-Mail Address_____ **Communication Preference:** ☐ **Phone** ☐ **Postal** ☐ **Email**

Race_____ **Guardian (if patient is a minor)**_____ **Relation to the patient**_____

REASON FOR VISITING OUR OFFICE TODAY _____

Blurred at: ☐ Distance ☐ Near ☐ Night Vision ☐ Eye Strain ☐ Dry Eyes ☐ Floaters ☐ Light Sensitivity ☐ Headaches ☐ Eye Pain

REVIEW OF SYSTEMS (check all that apply) **Date of last eye exam (approximately)** _____

	Self	Family	Relation	Maternal/Paternal		Self	Family	Relation	Maternal/Paternal
Macular Deg.	☐	☐	_____	M / P	Hypertension	☐	☐	_____	M / P
Cataracts	☐	☐	_____	M / P	Cholesterol	☐	☐	_____	M / P
Glaucoma	☐	☐	_____	M / P	Heart Disease	☐	☐	_____	M / P
Retinal Det.	☐	☐	_____	M / P	Thyroid	☐	☐	_____	M / P
Diabetes	☐	☐	_____	M / P	Arthritis	☐	☐	_____	M / P
Cancer	☐	☐	_____	M / P	Stroke	☐	☐	_____	M / P

Other _____

Have you had an Eye Injury/Surgery? ☐ Y ☐ N Are you currently pregnant? ☐ Y ☐ N Any Tobacco Use? ☐ Y ☐ N

Are you currently taking any medication?: ☐ Y ☐ N If yes, list the medication:_____

_____

Are you allergic to any medication? ☐ Y ☐ N If yes, list the medication: _____

_____

Insurance Information: Please provide your medical and vision insurance card to the doctor's assistant.

I am not filing vision or medical insurance _____(please check if this applies)

Primary Member's Name: _____ **Primary Member's DOB:**_____ **SS#:** _____
Employer _____ **Patient's Relation to member:** ☐ **Self** ☐ **Spouse** ☐ **Child**

Medical Insurance Co. _____	**Medical ID #** _____
Vision Ins Co. _____	**Vision ID #** _____
Medicare ID #:_____	**Secondary INS & ID #:**_____

By signing below, I acknowledge that:

- The information I have provided is accurate to the best of my knowledge.
- I may request a copy of U & M Family Eyecare, P.C. Notice of Privacy Practices (effective April 14, 2003; Amended September 2013), although it is posted in the office.
- If my **medical** or **vision** insurance does not pay for any services rendered, **I will ultimately be responsible for all monies owed.**
- I understand contact lens fitting fees ($40-$60) are due at the time of service and may require a follow-up visit which may be subject to additional fees if the patient fails to return within 30 days of the initial visit.
- I am financially responsible for all charges incurred today, including contact lens fees and I understand that professional fees are not refundable.
- I authorize payment of medical benefits of the undersigned physician or group for services rendered.
- By signing below, I understand and agree to allow U & M Family Eyecare, P.C. to file my claim.
- By signing below, I authorize the release of any medical or other information necessary to process this claim.

Patient or Guardian Signature_____ **Date**_____

DILATION

In order to thoroughly examine the internal structure of the eye, it is necessary to enlarge the pupil of the eye (dilation). This allows the doctor to observe the peripheral area of the retina that would otherwise be hidden from view. You may experience blurred vision for reading. Your distance vision will usually not be blurred, but it may seem a little distorted and it may be more sensitive to light. You will be able to drive after having your eyes dilated, but you should use extra caution. This also applies to all other physical activities such as walking, climbing stairs or curbs, etc.
There is NO additional charge for dilation.

_____ **Yes**, I **DO** want the Dilation. _____ **No,** I **DO NOT** want the Dilation

Patient / Guardian signature: _____ Date:_____

RETINAL IMAGING

A new technologically advanced camera now allows us the ability to take pictures of the back of the eye (retina, optic nerve, and macula) to screen for problems that can affect your vision. With this technology we are able to diagnose eye conditions such as **glaucoma, macular degeneration, diabetic and hypertensive retinopathy as well as Tumors from one visit to the next. This test is highly recommended on a yearly basis. There is an additional fee of $30.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional cost.**

VISUAL FIELD TEST FOR DETECTION OF VISUAL DISORDERS

Our new OCULUS VISUAL FIELD ANALYZER utilizes computer technology to electronically measure retinal function and contrast sensitivity. This test can also assist us in early detection of many disorders including **brain tumors, glaucoma, diabetic retinopathy and retinal detachments. This test is highly recommended on a yearly basis. There is an additional fee of $15.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional cost.**

Please check below:
_____ I would like to have the Retinal Imaging done
_____ I would like to have the Visual Field Examination done
_____ **I would like both (we are able to combine testing for $40.00-best value)**
_____ **I would prefer neither test at this time**

Patient / Guardian signature: _____ Date:_____

OPTICAL COHERENCE TOMOGRAPHY (OCT)

Optical Coherence Tomography or **OCT** is a sophisticated scanning system that produces highly detailed images of the **retina** and **optic nerve**. It is similar to an MRI or ultrasound of the back of the eye. OCT measures the retinal nerve fiber layer thickness in glaucoma and other diseases of the optic nerve and retina. **This test is highly recommended on a yearly basis. There is an additional fee of $30.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional costs.**

_____Yes, I would like to have the OCT Scan_____No, I would not like to have the OCT Scan.

Patient / Guardian signature: _____ Date:_____