Welcome to Great Hills Eye Care

Name: _____ Date of Birth: _____/_____/_____

Current Address:_____

City, State Zip _____ If Child (Guardian Name)_____

Email address: _____ Gender: M / F

Home Phone: _____Wk Ph: _____Cell Ph: _____

Occupation: _____Full Time/Part Time Place of Work: _____

Do you have family members that are seen here? If so, please list: _____

Eye and Medical History

Do you currently wear glasses? Y / N Do you currently wear contact lenses? Y / N

Are you here for: EYEGLASSES CONTACT LENSES RED EYE OTHER _____

How long since last exam _____

List current eye drops _____ Allergies to eye drops?_____

Have you had surgery on or around the eyes? Y / N Type _____ When_____

Past Eye History: Strabismus (Eye Turn) Amblyopia (Lazy Eye) Glaucoma Corneal injuries

Dry Eyes Iritis Retinal Detachment Retinal Disease Keratoconus Trauma

Family Eye History: Glaucoma Blindness Diabetic Retinopathy Macular Degeneration NONE

MEDICAL HISTORY: Diabetes? Y / N For how long?_____ High Blood Pressure? Y / N

List ANY other medical conditions_____

List ANY current medications_____

Allergies to medications? Y / N List _____

Retinal Imaging / OPTOMAP

We highly recommend having a retinal image taken as part of your annual eye exam. This allows the doctor to perform a much more comprehensive eye wellness exam and detect problems sooner than using the traditional microscope. There are no side effects. The images are saved to your chart so your eye health can be monitored over time.

-Retinal Imaging is $35 in addition to the regular eye exam.

Would you like to have Retinal Imaging performed today? Y / N

Visual Field Testing

Our office uses an advanced visual field analyzer to help detect Glaucoma and other eye diseases. It is recommended if you are over 40, have any family history of Glaucoma, high prescription, or other risk factors.

-Visual field testing is $30 in addition to the regular eye exam.

Would you like to have the Visual Field Test performed today? Y / N

Dilation

If you choose not to have retinal imaging performed, or if certain medical conditions are present, you may require dilation. Dilation allows the doctor to better evaluate the retina. The drops cause light sensitivity and blurry vision for up to 4 - 6 hours. **–Dilation is $30 in addition to the regular eye exam.**

Would you like to be Dilated today? Y / N

PLEASE COMPLETE REVERSE SIDE OF FORM

NOTICE OF PRIVACY PRACTICES

This form is posted in the office and we will gladly provide you with a copy of this notice if you would like to keep one for your personal records. This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Examples of uses of your health record information include patient recall, prescription verification or request, or for co-management with another health care professional.

Please sign, date, and print your name below indicating that you have been made aware of our privacy practices and offered a copy for your personal records.

Signature_____ Date: _____

(Please circle one: Patient or Guardian)

Printed Name _____

FINANCIAL RESPONSIBILITY AGREEMENT

- I am financially responsible for all charges incurred during eye exams or office visits to Great Hills Eye Care, P.C.
All Charges are non-refundable. Payment is due at time of service.

- **If my insurance is billed for services rendered and does not pay for ANY reason, I am responsible for full payment of remaining charges. Payment is due immediately upon receipt of statement from Great Hills Eye Care, P.C.** If I do not inform Great Hills Eye Care, P.C. of my insurance BEFORE services are rendered or if I have an insurance plan that Great Hills Eye Care, P.C. does not bill directly, payment in full is due at time of service and I am solely responsible for seeking reimbursement from my insurance provider. Great Hills Eye Care does not guarantee reimbursement from any insurance provider.

- Routine exams for eyeglasses include one follow up appointment within 60 days of the initial examination. **Any visits outside of the 60 days WILL INCUR an office visit charge.**

- Certain contact lens evaluations **including first-time wearers** carry an additional fee and many times this can only be determined after your discussion with the eye doctor about what type of contact lenses are suitable for your eyes. Contact lens evaluations cover up to 2 follow-up visits and these must be completed within 60 days of the initial contact lens evaluation. **Any visits outside of the 60 days WILL INCUR an office visit charge.**

- Routine eye exams **do not cover eye disease treatment or monitoring**. I have been informed that medical visits for red-eyes, dry eye/allergy treatment, foreign body removal (including contact lens and eyelash removal), and other **medical services may carry a higher fee than routine examinations**.

Signature_____ Date: _____

(Please circle one: Patient or Guardian)

If you are self-pay, please check here _____

If you are using insurance,
Please provide us with your most recent insurance card