New Patient Forms

Name:_____ D.O.B**:** _____
Address: _____ Home # _____
City, Zip:_____ Work # _____
Email: _____ Cell # _____
Would you like to be contacted by phone, text, or email?: _____

Social Security # _____ Marital Status:_____ Race/Ethnicity:_____
Employment Status: _____ Employer:_____ Occupation:_____

How were you referred to our office? □ Friend/Physician:_____
□ Google □ Yelp □ Facebook □ Office Website □ Other: _____

Do you wear glasses □ Yes □ No
Are you interested in contacts □ Yes □ No
Do you wear contacts □ Yes □ No
Are you interested in Lasik □ Yes □ No

Policy & ProceduresFinancial Agreement and Policy:

I understand that I'm fully responsible for the total cost of payment for all procedures and services performed at this office. I agree to pay my balance in full at the time of services, this includes unmet deductibles and Copays. We do require **a 50% deposit** on any optometric materials before an order can be placed. **Deposits for materials not picked up** within **90 days** will be forfeited. In our continued commitment to provide excellent and convenient services, we will first apply any insurance benefits to the best of our ability. We also take most payment options including Care Credit. ***All transactions are final. No refunds.***

Sign:_____ Date:_____

Receipt of Notice of Privacy Policies & Consent Form (Laminated Form):

I have read and understood the Notice of Privacy Practices from Advanced Family Eye Care. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations.

Sign:_____ Date:_____

I-Wellness Scan/ Fundus Photography Release of Liability Authorization:

Doctors are dilating patients only when the doctor determines it is medically necessary.*

Doctors recommend for all patients to have their retina evaluated annually to detect any eye health diseases. We have two options to choose from, *(choose one of the options below)*

Fundus Photography: An image of the retinal vasculature **(blood vessels)**, the optic nerve head, where retinal blood vessels enter the eye**. Your copay would be $20.**

□ Yes □ No

I-Wellness Scan**:** Two images taken (similar to an ultrasound or MRI) can show drusen, abnormal bleeding, scar tissue, Macular Degeneration, Glaucoma, Diabetes, high blood pressure & cholesterol. ***Your copay would be $39.***

□ Yes □ No

Medical History

Are you pregnant and or nursing? □ Yes □ No
Have you ever been exposed to or infected with?
□ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

Do you have any allergies to medications?
List:_____
Do you take medications?
List:_____
Have you had any major injuries, hospitalizations or surgeries?
List:_____
Do you have any eye conditions?
List:_____

Family History

Please check all conditions that apply. (parents,siblings, maternal/paternal grandparents and children: living or deceased)

Macular Degeneration □_____ **Glaucoma** □ _____
Retinal Detachment □_____ **Diabetes** □_____
High Blood Pressure □_____ **Cancer** □_____
Heart Disease □_____ **Arthritis** □_____
*Note:*_____

Social History

Do you smoke? □ No □ Yes If yes, amount /how long:_____
Do you drink? □ No □ Yes If yes, amount /how long:_____
Do you use narcotics? □ No □ Yes If yes, please define:_____

Review of Systems

Do you currently or have you ever had any problems in the following areas:

Ears, Nose, Mouth, Throat	□ Allergies/Hay Fever	□ Sinus Congestion	□ Runny Nose
	□ Post Nasal Drip	□ Chronic Cough	□ Dry Throat / Mouth
Constitutional	□ Fever	□ Extreme Weight Loss / Gain	
Neurological	□ Headaches	□ Migraines	□ Seizures
Endocrine	□ Thyroid / Other Glands		
Genitourinary	□ Genitals / Kidney / Bladder		
Gastrointestinal	□ Diarrhea	□ Constipation	
Bones / Joints / Muscles	□ Muscle Pain	□ Arthritis	□ Joint Pain
Respiratory	□ Asthma	□ Emphysema	□ Chronic Bronchitis
Vascular / Cardiovascular	□ Diabetes	□ High Blood Pressure	□ High Cholesterol
	□ Heart Pain	□ Vascular Disease	
Lymphatic / Hematologic	□ Anemia	□ Bleeding Problems	

Soft Contact lens fitting and evaluation policies and fees

Soft contact **lens fitting** and **evaluation Exams** are a **separate** professional service. Soft contact lens prescriptions are valid for one year from the date of finalized prescription. Fitting and evaluation fees are based on the complexity of your prescription and lifestyle needs.

(Prices listed below do not include contact lens benefits/Insurance)
(The Doctor will determine the benefit level)

Level 1 - **$95** Established patient evaluated with spherical contact lenses previously fitted at this office with no changes in lens type or material. Finalized the same day.

Level 2 -$120 New or established patient fitted and evaluated with spherical contact lens; single powered lens includes **2 follow-up** evaluations within **30 days** from the initial exam

Level 3- $140 New or Established patient fitted & evaluated with toric lens (astigmatism) **(example: colored contact lenses, daily and monthly replacements)** includes **2 follow up** visits with in **30days** from initial visi**t**

Level 4- **$165** New or established patient fitted & evaluated with multifocal lens. (For the correction of distance and near vision) Includes **3 follow up** visits within **45 days** from the initial contact lens exam.

Level 5- **$275** New or established patient exam & evaluation of multifocal-toric contact/ monovision (For the correction of distance/near with patients that have astigmatism. Includes **5 follow** up evaluations with **insert removal training: $30**
You must return to the office for contact lens follow-ups. Be sure to be **wearing** the **contact lenses** that you received from this office when you return for your **follow-up visit.** This is so the doctor can evaluate the lenses after they have been in your eyes for a period of time. If for some reason you're not able to wear contact lenses to the appointment please call the office before your follow-up visit and a new set of contact lenses will be given to you.

Additional contact lens follow up exams are $45 per visit. Office visits that fall outside the prescribed timelines for each level will be subject to additional exam fees.
Lenses purchased cannot be returned or exchanged after 30 days. Contact lens **boxes** must be **unopened and unmarked** for us to return to the manufacturer. **Custom** orders cannot be returned.
We are not responsible for the accuracy or quality of lenses purchased outside of the office. Patients who purchase outside of the office are not eligible for courtesy contact lens replacements.

I have read and understand the above policies:

Print Name: _____