Welcome to our office. The following information will assist your doctor with the examination.
(If you need help completing this form, ask at the desk.)

Last Name_____ First Name_____ MI____ Date _____

Address_____ City_____ State_____ Zip_____

Telephone (W)_____ (H)_____

SSN_____ Date of Birth _____

Occupation_____ Insurance Type_____

Employer_____ Insured's Name_____ DOB _____

Emergency Contact/Telephone Number _____

Date of last eye exam_____ Dilated?_____ Today's Date _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these symptoms? *(Please circle all that apply)*

Eyes	Yes / No				
Gastrointestinal	Yes / No	Nervous	Yes / No	Mental	Yes / No
Ears/Nose/Throat	Yes / No	Genitourinary	Yes / No	Endocrine (glands)	Yes / No
Cardiovascular	Yes / No	Musculoskeletal	Yes / No	Blood/lymph	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Allergic/immunologic	Yes / No

Please explain _____

Please answer all that apply:

Diabetes Yes / No Type_____ Date of diagnosis _____

Allergies Yes / No Allergic to what?_____ What happens? _____

Medication allergy Yes / No What happens?_____ Headaches Yes / No

Other health problems _____

Current medication(s)_____

Have you had any operations? Yes / No Kind?_____ When? _____

Do you use cigarettes/tobacco?_____ Alcohol?_____ Other substance(s)? _____

Name of family doctor_____ Date of last visit _____

Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure Yes / No Relation_____ Macular degeneration Yes / No Relation _____

Diabetes Yes / No Relation_____ Retinal detachment Yes / No Relation _____

Glaucoma Yes / No Relation_____ Cataracts Yes / No Relation._____

Other eye condition(s) Yes / No What kind?_____ Relation _____

PERSONAL INFORMATION

Have you had an eye operation? Yes / No Type_____ Date _____

Have you had an eye injury? Yes / No Kind_____ Date _____

Do you have glaucoma? Yes / No Cataracts? Yes / No Dry Eyes? Yes / No Blurred Vision? Yes / No

Other eye problems? Yes / No What kind? _____

Do you wear glasses? Yes / No Contact Lenses? Yes / No Type _____

Additional Information_____

Whom may we thank for referring you?_____

Doctor's Initials_____ _____

FORM 79

Eye Care One

Welcome To The 21st Century

Dear Patient:

We offer two highly sophisticated tests that allow us to provide you with a more thorough medical analysis of your eye. One is a **digital retinal imaging system**. It takes images of the retina (the back of your eye). The other is a **visual field examination**. It measures retinal function and sensitivity to light. These procedures assist the doctor in the early detection of many disorders, including **glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, brain tumors and other vision threatening conditions**. The results will be stored in the computer and compared with results of future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.

The doctor strongly recommends that all patients have this procedure performed. It is especially important for people who have:

1.) **Excessive, unexplained, or recent on-set headaches**
2.) **See spots or flashes**
3.) **Family history of diabetes, glaucoma, or high blood pressure**
4.) **High cholesterol**
5.) **History of Multiple Sclerosis**
6.) **History of circulatory problems**
7.) **Reached the age of 40**
8.) **Vertigo**
9.) **Patients taking planquenil (for Arthritis)**
10.) **Patients with Amblyopia (lazy eye)**
11.) **New patient**

There is a combined charge of $40.00 for these two procedures. If a diagnosis is made because of this procedure, medical insurance may cover the cost. Please check the appropriate line below and sign the bottom line.

_____ I DO want these procedures performed.

_____ I DO NOT want these procedures performed.

Signature Date

Eye Care One

Dr. Chad R. Nixon, O.D.
Dr. Donald V. Greene, O.D.

Dear Patients,

We would like to welcome you to our office and inform you of our office policies. Hopefully, this will enable us to better serve your eye care needs. If you ever have any questions please feel free to ask them.

* Our goal is to provide you the utmost in vision care using state of the art technology and equipment.

* **ONE YEAR WARRANTY POLICY FOR $30.00**. One time replacement on lens and frame. Every replacement after at a 50% discount. Warranty must be bought at time of purchase. This does **NOT** cover loss.

* We accept most insurances. If we are not a provider of your insurance, we will be happy to fill out any forms you need to send in for reimbursement, but you are responsible to pay for all services at the time they are rendered.

* If we do not receive payment from your insurance company within ninety (90) days of filing the claim, you will be responsible for the balance.

* Professional fees and insurance co-pays are due the date of service. There is a minimum requirement of half down on all on-site lab work. All materials must be paid for in full in before the patient leaves the office with them.

* We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription. Also, all spectacle lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. For all of these reasons, cash refunds are not possible. At the doctors' discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted at no cost within 30 days of the original purchase.

* **Progressive Non- Adapt Policy** - If despite your efforts and ours, you are unable to adapt to your new lens style within 30 days, we will remake your lenses one time at no charge into a lens that is suitable. There will be no refund on the difference.

* All minors under the age of 18 years must be accompanied by a parent or guardian. This is to ensure proper visual treatment for the patient and communication between our office and the person responsible for payment of services.

* All returned checks are subject to a $25.00 returned check fee and must be made good within 48 hours of the return check notice.

* A copy of the HIPPA Privacy Act was made available to me at my time of service. A copy was available for me to keep if I desired.

_____

Patient/ Guardian Signature Date

Eye Care One
Vision and Medical Insurance Release

Date:_____

As part of our service at Eye Care One we are happy to assist patients in determining the benefits of each individual policy and in collecting reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. Legal obligations, policies, co-pays, coverage, and lab services of your insurance provider are between yourself and your provider, not between Eye Care One and your provider.

2. When your insurance provider (s) have settled your plans covered items, a monthly statement will notify you if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapse, ineligibility, or termination of coverage's. Unpaid balances are the sole responsibility of the patient.

3. To keep the cost of records and collections down, any patient portion amounts on your order will be due at the time of service.

Additional information required to process your claim:

Patients name: _____ Sex: M or F Birth date:_____

Relationship to insured: _____ Primary Care Physician name: _____

Primary policyholders name:_____ Birth date: _____

Primary insurance company: _____ SS# or contract # _____

Secondary policy holders name: _____ Birth date: _____

Secondary insurance company: _____ SS# or contract# _____

Responsible party/ patient signature_____