Welcome to ModernEyes Eyecare + Eyewear! We are excited to see you today. Please help yourself to some coffee or tea. If you'd like water, please feel free to ask as we have some in our refrigerator and would be happy to get it for you.

Eye exams can be classified as two different types of exams: routine and medical. The differences in the exams dictate what insurance plan we bill, so we need to know what medical insurance and vision plans you may have.

Vision Benefit: This is a routine exam that addresses a glasses and/or contact lens prescription along with assessing the overall health of the eye. If eye health problems are noted, a follow up exam would be scheduled and your medical insurance would be billed.

Medical Insurance: This is an office visit for such conditions as glaucoma, diabetes, macular degeneration, dry eye, or red eye/injury. Most complaints of pain, redness, swelling, itching, and loss of vision are related to eye health and would most likely be diagnosed as medical.

Some offices may have utilized your Vision Benefit for both routine & medical eye care at your yearly exam. Due to the ever-changing landscape of healthcare, we are forced to split your eyecare into the two designations above. We apologize for any inconvenience this may cause, but are unwilling to compromise the integrity & excellence this office strives to provide. Thank you for your cooperation.

At ModernEyes Eyecare + Eyewear, we offer several advanced technology screenings:

Fundus Evaluation: All ages

Comprehensive exams include fundus (retinal) evaluation and are an important part of your eyecare, as it allows the doctor to see the entire retina to check for holes, tears, detachments, as well as signs of diseases such as diabetes or tumors in the eye. There are two main ways to evaluate the health of the inside of the eye.

1. The preferred method is to use the *Optos*, which obtains a near full-field image of the internal eye. We review the images and can use the viewing software to measure and notate any abnormal findings. There are no side effects with utilizing the retinal camera to evaluate the internal eye health.
2. The second method is to use *dilation drops* to enlarge the pupils to allow for better viewing of the inside of the eye. The drops used to dilate the eyes will cause blurred vision (usually worse reading than distance) & light sensitivity for several hours. We do not charge extra for routine pupil dilation. From time to time, we may have to perform a stronger dilation, but will discuss with you if the need arises.

□ Yes, I agree to have Optos retinal photos. I understand I will be charged $39 (non-bundled) for this service unless it is covered by my Vision Benefit. I also understand that if the doctor sees something concerning on the photos, pupil dilation may be required for additional evaluation.

□ I would prefer to have my pupils dilated

Women Only: Are you pregnant or nursing/pumping? □ Yes □ No

Optical Coherence Tomography (OCT): Typically for 16 years old and over

OCT is a non-invasive diagnostic instrument similar to an MRI scan that is used to allow doctors to see a 3D image of the retina and detect problems in the eye prior to any presence of symptoms. OCTs are commonly used to detect the top three diseases known to cause blindness: macular degeneration, glaucoma, and diabetic retinopathy, among other problems. When used as a screening tool, we obtain images of both the optic nerve and macula of each eye.

□ Yes, I agree to have a screening OCT performed today. I understand I will be charged $39 (non-bundled) for this service.

□ I would like to talk to the doctor about this option

***BUNDLE & SAVE: If you opt for both photos and OCT, you will be charged $60 (an $18 savings)**

_____ _____

Signature Date

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Patient Information

PATIENT CONTACT INFORMATION

Legal Name _____
Preferred Name _____
Address _____
City _____ State _____ Zip _____
DOB _____ / _____ / _____
SSN# _____ - _____ - _____
Preferred Phone _____
Email _____
Emergency Contact _____

Occupation/Student Status _____
Maritial Status _____
Guardian (If Applicable) _____
Name of Medical Doctor _____
Race & Ethnicity _____
Gender _____
OK to leave a message? _____
How did you hear about us? _____
Emegency Contact Phone # _____

INSURANCE INFORMATION

Vision

Insurance Name _____
Member ID _____

--Policy Holder's Information If Different From Above--

Policy Holder _____
Relationship to Insured _____
Policy Holder Employer _____
Insured DOB _____ / _____ / _____
Insured SSN# _____ - _____ - _____
Insured Address
Address _____
City _____
State _____ Zip _____

Primary Medical

Insurance Name _____
Member ID _____

--Policy Holder's Information If Different From Above--

Policy Holder _____
Relationship to Insured _____
Policy Holder Employer _____
Insured DOB _____ / _____ / _____
Insured SSN# _____ - _____ - _____
Insured Address
Address _____
City _____
State _____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION & PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign pertinent medical and/or surgical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, private insurance and any health and/ or vision plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims.

AUTHORIZED SIGNATURE _____ **DATE** ____/____/_____

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Medical History Questionnaire

PERSONAL & FAMILY MEDICAL HISTORY (Family = Mother, Father, Siblings & Children)

Disease/Condition	None	Self	Family	Relation	Disease/Condition	None	Self	Family	Relation
Blindness	☐	☐	☐		Glaucoma	☐	☐	☐	
Cataracts	☐	☐	☐		Macular Degeneration	☐	☐	☐	
Eye Injury/Surgery	☐	☐	☐		Dry Eye	☐	☐	☐	

Please Circle or Write In if Not Listed

Constitution (Developmental Disabilities, Cancer, etc)	☐	☐	☐		Gastrointestinal (Crohn's, Colitis, Celiac Disease, etc)	☐	☐	☐	
Ear/Nose/Throat (Tubes, Sinusitis, etc)	☐	☐	☐		Genitourinary (Kidney, Prostate, STD, etc)	☐	☐	☐	
Neurologic (MS, CP, Stroke, Migraine, etc)	☐	☐	☐		Musculoskeletal (Arthritis, Muscular Dystrophy, Ankylosing Spondylitis, etc)	☐	☐	☐	
Psychologic (Depression, Anxiety, ADHD, etc)	☐	☐	☐		Integumentary (Eczema, Rosacea, Psoriasis, Shingles, etc)	☐	☐	☐	
Cardiovascular (High Blood Pressure, Stroke, Heart Failure, etc)	☐	☐	☐		Endocrine (Diabetes, Thyroid, Hormonal, etc)	☐	☐	☐	
Respiratory (Asthma, Sleep Apnea, COPD, etc)	☐	☐	☐		Hematologic/Lymphatic (Anemia, High Cholesterol, etc)	☐	☐	☐	
OTHER: _____	☐	☐	☐		Allergic/Immune (Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, etc)	☐	☐	☐	

CURRENT MEDICATIONS (Presription & Over-the-Counter)

Allergy Meds _____
Blood Pressure Meds _____
Cholesterol Meds _____
Diabetic Meds _____
Eye Drops _____

Oral Contraceptives _____
Other Medications _____
_____
MEDICATION ALLERGIES _____
_____

SOCIAL HISTORY

Do you drink Alcohol? ☐ No ☐ Occasionally ☐ 1/day ☐ 2-3/day ☐ +4/day
Do you Smoke? ☐ No ☐ 1-2 packs/week ☐ 3-4 packs/week ☐ 1+pack/day
Previous Smoker? ☐ No ☐ Yes
Do you use controlled substances? ☐ No ☐ Yes If Yes, What kind? _____
Height: Weight: