ELKIN EYE CARE

Check-In Information

Dr. Kala Brewer

First Name:_____ Last Name: _____ DOB: ___/___/_____ Sex: M / F

If patient is a minor, list name of parent or guardian: _____SSN:_____

Mailing Address:_____City:_____ State:_____ Zip: _____

Home phone:_____ Cell phone:_____ Email:_____

Employer:_____ Occupation:_____

Emergency Contact Name & Phone:_____

Primary Care Doctor & Date of Last Visit: _____

Preferred Pharmacy _____

Eye or Vision concerns today? _____

Do you wear contact lenses? Y N Do you want to continue wearing contact lenses? Y N

Medications: None ☐ I have a list to give to the front desk ☐ Otherwise, please list below:

_____

_____

Please list all drug or other Allergies and reactions:_____

_____

Personal Medical History ***(Circle all that apply)*** ☐None Pregnant/Nursing? Y N N/A

Ear/Nose/Throat: Hearing loss, Vertigo, Dry Mouth, Sinus Disease

Neurological: Migraines, Multiple Sclerosis, Seizures, Epilepsy

Psychiatric: Depression, Anxiety, ADHD

Cardiovascular: Hypertension, Heart Disease, Congestive Heart Failure, Stroke, Heart Attack

Respiratory: Asthma, Sleep apnea, COPD, Emphysema

Autoimmune/ GI/ GU: Rheumatoid Arthritis, Crohn's, Ulcerative Colitis, Liver Disease, Kidney Disease

Muscular/skeletal: Arthritis, Fibromyalgia, Muscular Dystrophy

Integumentary: Rosacea, Psoriasis, Eczema, Shingles

Endocrine: Thyroid disease, Type 1 diabetes, Type 2 diabetes Last A1C %_____

Hematologic: High Cholesterol, Anemia, Bleeding Disorder

Infectious: Herpes simplex, Tuberculosis, HIV +, Hepatitis

Cancer:_____

Other Conditions: _____

Please list any personal eye history (surgeries, injuries, diseases):_____

☐ Dry eye ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Crossed eye/Lazy Eye ☐ Uveitis/Iritis

☐ Eye Injury ☐ Retinal Detachment ☐ Eye Surgery Explain:_____

Please indicate who in your immediate family has had high blood pressure, diabetes, heart disease, cancer, thyroid disease, or multiple sclerosis (Example: mother - diabetes): _____

_____

Please indicate who in your immediate family has had glaucoma, macular degeneration, blindness, a lazy or crossed eye (Ex: father - glaucoma): _____

*Present current **Medical** ***and*** **Vision** insurance cards with this form

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- **Retinal Photography (Optomap): $39**
    - Obtained at **ALL** comprehensive eye exam visits to increase detection/monitoring of eye diseases in the retina (back of the eye). Please let the front desk or assistant know if you suffer from seizures or epilepsy triggered by flashing lights
    - *Vision plans include retinal screening in their benefits with a copy of $39. Medical insurance can be applied in the presence of pathology. Copays, deductibles, and coinsurance may apply. Cost is included in cash pay exams. Please ask the front desk for clarification about your specific insurance plan if needed.*
- **Optical**
    - Frame Adjustments, Repairs, Warranties, Fit modifications, etc are provided as a courtesy at *NO COST to patients who purchase eyewear in our Optical*.
        - If you are unsatisfied with your frame, our office will accommodate a one time frame restyle within 30 days of purchase.
        - Problems with lenses must be reported within 90 days from purchase date.
    - Eyewear/Contact Lens prescriptions filled outside our office will NOT receive the benefits listed above.
- **Contact Lenses**
    - Contact lenses are considered a medical device and are regulated by the FDA.
    - Trial contact lenses are given only for the purposes of determining the correct fit and vision; once your prescription is finalized, you will need to order your own supply before you are due to replace them. A copy of your final prescription, valid for 12 months, will be emailed to you, or you can receive a printed copy
    - Problems with vision or comfort must be reported within 90 days of your contact lens evaluation. After 90 days, additional fees may apply.
- **Insurance**
    - **All insurance information must be provided at time of service.**
    - As a courtesy, we file all In-network and a select number of Out-of-network policies. You will be responsible for any copays, deductibles, or non-covered procedures
    - Medical based complaints and exams will be billed to your medical insurance policy.
    - Vision / wellness exams are for the purpose of checking vision, screening for eye disease, and/or updating eyeglass or contact lens prescriptions. They do not cover additional medical testing.
    - A refraction is performed to determine your best vision and to be able to give a new/updated glasses prescription. Medical insurances do not cover the refraction fee of $30

A Break in Appointment Fee of $50 will be billed to you if you do not give at least a 24 hour notice prior to canceling or rescheduling your appointment. This fee is the sole responsibility of the patient and must be paid in full before the next appointment.

I have read, understood, and agreed to the Elkin Eye Care policies listed on this page (sign below):

Signature_____ Date:____/_____/_____