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:

____

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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): ______________________________

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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** (out of pocket)
    - Option to increase detection/monitoring of eye diseases in the retina (back of the eye) by allowing us to take images with our state of the art Widefield Retinal Camera. In most cases photos can be taken without the need for dilating drops. *(medical insurance may cover fee in presence of pathology)*
        - [ ] I CHOOSE to have a digital retinal photo taken of the back of the eye. I am responsible for the $39 charge
        - [ ] I DECLINE a digital retinal photo. I understand that I will have my eyes dilated for a comprehensive check
- **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 and may be subject to charges if the outside glasses need adjusting

- **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 exams will be billed to your medical insurance policy.
    - 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 a refraction fee
    - Vision exams are solely for vision purposes and do not cover additional medical testing.

A no-show 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 filled out this form accurately and to the best of my knowledge. I have read, understood, and agreed to the Elkin Eye Care policies listed on this page (sign below):

Signature______________________________ Date:____/_____/_______