



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** (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

● **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.

I have filled out this form accurately and to the best of my knowledge. I have read and understand the Elkin Eye Care policies listed on this page (sign below):

Signature _____

Date: ____/____/____