



Established Patient

Patient Information

Name _____ Birth Date _____ Gender: M or F
Address _____ City/State/Zip _____
Phone _____ E-mail _____

How would you prefer to be contacted? Call Text Email

If you would like access to our patient portal, please ask our staff at checkout.

Name of primary care physician _____ Location/Office of primary care _____

Ocular History

Do you wear **contact lenses**? Y / N Are you happy with your vision and comfort in your lenses? Y / N _____

Have you had **cataract surgery**? Y / N Which eye: Right Eye Left Eye Both Eyes

Have you had **any new eye surgery**? Please explain. _____

Have you been diagnosed with **macular degeneration** or **glaucoma**? _____

Please list any eye drops. _____

Personal Health History. (Please check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizure/Epilepsy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Trauma/TBI | <input type="checkbox"/> Lupus | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Neurological Problem | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychological Disorder | <input type="checkbox"/> Thyroid Disorder |

Other medical condition(s) _____

Any **changes to your medications** or **provide a list of your medications.** _____

Are you **allergic to any medications**: _____

Retinal photo screening

An important part of your eye exam is the retinal evaluation. The doctor evaluates **the health of your body** by looking at the optic nerve, macula, blood vessels, and other parts of your eye. In addition to the doctor looking at the retina with their equipment, it is helpful to have a retinal photo on file to monitor changes year to year. A retinal photo can help see early signs of **macular degeneration, glaucoma, diabetes, high blood pressure and other retinal diseases.**

We offer this service for a **discounted fee of \$25** because it is generally not covered by insurance, unless being used to actively follow ocular disease. Would you like to have a **retinal photo** performed today? Yes No Not Sure



Release to discuss medical information to family member (optional)

Do we have your permission to discuss your medical information with a family member or friend? || Yes || No

If yes, whom: _____ Relationship: _____

Emergency Contact: _____ Phone: _____

HIPAA PRIVACY (required)

By signing this acknowledgement of Receipt of Notice of Privacy Practices. I acknowledge and agree that I have received, or I have been provided the opportunity to receive a copy of Salomon Eye Care Notice of Privacy Practices that explains when, where, and why my confidential health information may be used or shared.

I acknowledge that Salomon Eye Care, the physicians, and other staff may use and share my personal health information with others in order to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Salomon Eye Care. **The HIPAA Privacy form must be signed every year.**

Patient Signature _____ Date _____
(or legal guardian if minor)

Release of Medical Information (required)

ASSIGNMENT OF BENEFITS: I voluntarily direct my insurance company (or Attorney at Law) to pay Salomon Eye Care directly for charges for professional services rendered to me. **THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY.** I agree that I am responsible for any balance over and above insurance/attorney payment for these services.

CONSENT TO TREAT: I voluntarily authorize Salomon Eye Care to administer examinations and care as deemed necessary for my condition.

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case

Patient Signature _____ Date _____
(or legal guardian if minor)

For Medicare Supplements Only

REFRACTION CHARGE - Advance Beneficiary Notice of Noncoverage (ABN)

The refraction is part of the eye examination performed by your doctor to determine the prescription for your glasses and/or contact lenses. If there has been a decrease in vision, we must determine if a change in glasses will improve vision. Medicare does not pay for the refraction because they do not consider it a "medical" portion of the exam. You will be responsible for this charge at the time of your visit. We will not suggest refraction if we do not feel it is necessary.

Refraction Services Fee: \$20 I understand the above-mentioned charges and agree to make payment if a refraction is performed during my visit.

Patient Signature _____ Date _____