Welcome To Atlanta Eye Center

Name: ______________________________________ Date of Birth: ____________________

Current Address:____

City, State Zip _______________________ If Child (Guardian Name)______________________

Email address: ____________________________ SSN# _______________________________

Home Phone: _______________Wk Ph: ________________ Cell Ph: ___________________

Please check the following : __ Married __ Single __ Widow __ I do not wish to disclose

Occupation: _________________________ Place of Work: ____________________________

Who may we thank for referring you to our office?____

Do you have family members that are seen here? If so, please list: __________________________

Payment Method
Please Check Here If You Are Self Pay :______

Vision Insurance Information

Name of Insurance Plan:________________________ Name of Insured:___________________________________

Name of Employer: ___________________________ Primary holder SS# _________________________________

Medical Insurance Plan

Please submit your medical insurance card to us. We take Medicare, Medicaid, United Health Care, Humana, and BCBS PPO for eye exams.

Insurance Authorization

I authorize and request my insurance company to pay directly to the eye doctor benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: X____Date_______________

Privacy Policy
All doctor's offices must keep your information confidential due to laws known as HIPAA. We have given you our policies in regards to how we process your information on a separate sheet attached to this clipboard. Please sign below stating that you have read our statement or simply write "I decline to sign." (Your signature simply represents we attempted to share with you our HIPAA policies.)

Signature: X____Date_____________

Dilation
Dilation of the eyes allows us better evaluate the internal health of your eyes and **it is recommended**. The drops will enlarge the pupils so that we can get a better look inside; however, the drops will cause you to have blurred **near** vision and be sensitive to light for 2-3 hours. There is no extra charge for this test. Would you like this test? Please circle your choice.

Yes No

Visual Field Screening
In a matter of minutes, our Visual Field test allows us to screen for problems such as diabetes, hypertension, and tumors on the inside of your eye that can affect the optic nerve and retinal tissue. This advanced technology allows us to detect problems **earlier** than a regular eye exam. There is an additional fee of $26.00 for this test. Would you like this test? Please circle your choice.

Yes No

Please record your signature to acknowledge your choices:X_________________________

Name ____ Date __________________

History Information

During your visit today please circle if you would like a prescription for: Glasses Contact lenses

Hobbies, Sports: ____

To provide you with the best care possible, we need the following information:

Medications:

Please list any medications you are taking and what they are for: ____

____

____

Please list any allergies to medications you are aware of:

____

Who is your medical doctor? ___________________________________ Date of last exam: _____________________

Who was your last optometrist? ______________________________ Date of last eye exam:____________________

Medical Information:

Please place a **check** in the blank if the described condition applies to you.

Allergies

Do you have seasonal allergies? ____

Itchy eyes? ____

Chronic sinus infections? ____

Medical Health

Do you have high blood pressure? ____

A history of stroke? ____

Diabetes? ____

High cholesterol? ____

Asthma or lung problems? ____

Arthritis ____

Thyroid condition? ____

HIV or AIDS? ____

Contact Lenses

Ocular Muscles

Do you have strabismus (turned eye)? ____

Prism in your glasses? ____

Did you ever have vision therapy? ____

Do you ever see double? ____

Ocular Health?

Do you have glaucoma? ____

Do you have amblyopia (lazy eye)? ____

A history of ocular trauma ____

Watery /Burning eyes? ____

Cataracts? ____

A history of an eye surgery? ____

Floaters? ____

Have you ever had a retinal detachment? ____

Macular degeneration? ____