Appointment Check-In Form
Welcome To Experts On Sight

Appointment Time Today:_____ Arrival Time:_____

First Name:_____Last Name:_____

We are now making greater use of e-mail and text messaging to communicate with our patients. To help us provide the most prompt service possible, please enter your most current email and cell phone numbers below:

Email:

□@yahoo.com □@gmail.com □@hotmail.com □Other: @_____

Cell Phone: _____ - _____ - _____

NOTE: All patient information is kept **STRICTLY CONFIDENTIAL**. Your email or cell phone is **NEVER SHARED**.

Would you like to receive information regarding promotions and special events? Yes___No___

INSURANCE INFORMATION

If we are billing your vision/medical insurance for this visit the following information is **MANDATORY:**

Patient Information *Please furnish this information exactly as it appears on your insurance card*

Name of Patient: _____ Date of Birth: _____

Name of Vision Insurance Company: _____

Name of Medical Insurance Company: _____

Patient's Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time student ☐ Part-time student

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Primary Insured Information

Name of Insured: _____ Date of Birth: _____

Insured's Identification/Social Security Number: _____ Insured's Employer _____

Insured's Address: _____ City/State/Zip _____

Insured's Telephone Number: _____ Work Number: _____

Patient's or Authorized Person's Signature

IT IS YOUR RESPONSIBILTY to read and understand your insurance policy. The insurance company may not cover certain services and procedures, and you may have an annual out-of-pocket deductible that must be paid by you for vision services. It is also your responsibility to provide the correct insurance information. If you fail to do this, you will be responsible for the payment of services provided by Experts on Sight. In addition, any fees rejected by your insurance company will ultimately be your responsibility to pay.

I authorize payment of medical benefits to Experts on Sight for all medical services provided.

I authorize the release of any medical or other information necessary to process this claim.

I acknowledge that the above information is true and accurate to the best of my knowledge.

Signature _____ **Date** _____

OFFICE USE ONLY

Contact Name _____ Approval Code _____

Effective Date of Plan # _____ Co- Payment _____

Associate Initial _____ Extra Payment (CL fitting, dilation, etc) _____

Ins. Payment Received _____ Patient Total _____

HCFA Printed _____ Ins. Payment _____

EXPERTS ON SIGHT

Welcome to our office! Please provide us with the following information in order to help us serve you better.

LAST NAME _____ FIRST NAME _____

TODAY'S DATE _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

HOME PHONE _____ WORK/CELL PHONE _____

OCCUPATION _____ HOBBIES _____

FAMILY PHYSICIAN _____ PHYSICIANS PHONE _____

DO YOU HAVE VISION INSURANCE? Yes No
If yes, please verify that we accept your vision plan before your examination. Not all plans are accepted. Thank you!

EMAIL _____

HOW DID YOU DISCOVER OUR OFFICE? _____
Help us to thank the person who referred you!

TO WHOM MAY WE RELEASE YOUR INFORMATION: _____

Medical History *This information is kept strictly confidential*

Please check any conditions below for which you or a family member have ever been diagnosed or treated:

	Self	Family
Constitutional		
Fever / Weight Loss / Gain	☐	☐
Integumentary (skin)	☐	☐
Neurological	☐	☐
Endocrine		
Thyroid / Other _____	☐	☐
Ear / Nose / Throat	☐	☐
Respiratory	☐	☐
Vascular / Cardiovascular		
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease / Heart Attack	☐	☐
Stroke	☐	☐
Gastro Intestinal	☐	☐
Currently Pregnant or Nursing	☐	

	Self	Family
Genitourinary		
Kidney / Bladder / Genitals	☐	☐
Bones / Joints / Muscles		
Arthritis	☐	☐
Other _____	☐	☐
Lymphatic / Hematological		
Anemia	☐	☐
Other _____	☐	☐
Immunologic	☐	☐
Psychiatric	☐	☐
Cancer	☐	☐
Other _____		
Tobacco Use Former	☐	
Tobacco Use Current	☐	

Please list any medications you are currently taking (include over-the-counter, vitamins or supplements):
If you have a written list, the receptionist would be more than happy to make a copy.

_____

_____

Please list any allergies you have (include medications, foods, animals, etc):

_____

We are a HIPAA Compliant Office.

Ocular History

Please check any conditions below for which you or a family member have ever been diagnosed or treated:

	Self	Family		Self	Family
Cataracts	☐	☐	**Blindness**	☐	☐
Glaucoma	☐	☐	**Eye Surgeries**	☐	☐
Macular Degeneration	☐	☐	**Eye Injuries**	☐	☐
Retinal Detachment / Disease	☐	☐	**Eye Infections**	☐	☐
Lazy Eye	☐	☐	**Cross Eyes**	☐	☐
Flashes of Light / Floaters	☐	☐	**Other** _____		

Pupil Dilation Information

Because our office is committed to your eye health as well as ensuring you the best possible vision, we recommend pupil dilation in addition to the routine eye examination.

What is pupil dilation?
Pupil dilation is the use of eye drops that temporarily enlarge your pupils. Without dilation the doctor can see approximately 40% of the inside of your eye. Dilation gives the doctor a larger, three dimensional view of the interior eye. This allows the doctor to diagnose potentially serious eye problems before they affect your vision.

Do I need it?
The doctor recommends pupil dilation for all patients, regardless of age, at their first eye examination and every few years afterwards for routine eye health maintenance. It may need to be done more frequently if a problem is detected, or if your eye health cannot be properly monitored without it. Pupil dilation is particularly important and should be done annually if you have any of the following:

Diabetes, Cancer, High blood pressure, Glaucoma, strong eyeglass prescription, history of retinal problems, frequent headaches, or a family member with any eye disease.

What are the side effects?
Blurred near vision and light sensitivity for up to 6 hours. Driving is not usually impaired, but may require extra caution.

Contact Lens History *If applicable.*

Indicate which type of contacts you have worn in the past: *Check all that apply*

- ☐ Conventional (Annual Replacement) Soft
- ☐ Disposable Soft
- ☐ Monovision/Bifocal
- ☐ Toric (for astigmatism)
- ☐ Extended Wear
- ☐ Other _____
- ☐ Hard/Gas Permeable
- ☐ Color

Do you currently wear contact lenses? ☐ Yes ☐ No

Name: **LIFESTYLE QUESTIONNAIRE**

I currently wear:

□ Eyeglasses □ Contacts □ Sunglasses

Regarding my current eyewear, I am "dissatisfied" with the:

□ Vision □ Comfort □ Look/Style

Please check all that apply:

□ I spend a lot of time outdoors

□ I have trouble seeing/driving at night

□ I am bothered by glare or reflections

□ My job/lifestyle involves both indoor and outdoor activities

□ I am uncomfortable with the weight and or thickness of my glasses

□ I am light sensitive or driving in bright sunlight bothers me

□ I have trouble with close work while
□ reading □ using the computer □ partaking in my hobbies

□ I participate in active or competitive sports

□ My current eyewear doesn't meet my performance needs for work/recreation

□ I spend more than two or three hours a day at the computer

□ I am tired of always having to switch from regular eyeglasses to sunglasses

□ I am a bifocal wearer having trouble seeing at certain distances

□ I want a no-line bifocal (progressive) , but want to have trendy, small frames

□ I would like to wear contacts, but have been told I am not a candidate

□ I am considering having laser corrective surgery

Risk Assessment For Macular Damage (AMD)

How many hours a day do you spend on your computer, phone or tablet device? _____

How many servings of colorful fruits & veggies do you eat each day? _____

What vitamins/supplements are you currently taking any for eye health?_____

_____

Please Circle Y or N for Screening Questions

Do you have a family history of **Macular Degeneration**?	Y	N
Do you smoke?	Y	N
If no, have you ever smoked or been exposed to second hand smoke?	Y	N
Do you have light colored eyes and/or complexion/hair?	Y	N
Has your primary care doctor told you to lower your weight?	Y	N
Do you take medication for cardiovascular disease or diabetes?	Y	N
Have you had cataract surgery?	Y	N
Do you spend more than an hour outside each day?	Y	N
Do you have problems with glare when driving at night or when using your computer?	Y	N

If you answered yes to 2 or more of the screening questions you may be at risk.

Last Name: _____ First Name: _____

RETINAL IMAGING

We at Experts On Sight are proud to offer highly advanced Scanning Laser Retinal Imaging, which allows us to take images, safely, quickly and easily. A Scanning Laser Retinal Exam produces an image that is as unique as your fingerprint and provides us with a high resolution look at the health of your retina.

Many eye problems can develop without you knowing. You may not even notice any change in your sight. But, diseases such as macular degeneration, glaucoma, other health problems such as diabetes and high blood pressure can be seen with a thorough exam of the retina.

Retinal Exam provides:

- A scan to show a healthy eye or detect disease.
- A more detailed view of the retina, giving your doctor an image that can't be obtained by any other means.
- The opportunity for you to view and discuss the Retinal Image of your eye with your doctor at the time of your exam.
- A permanent record for your file, which allows us to view your images each year to look for changes.

We strongly recommend that all of our patients receive this evaluation. It is especially important for those patients who spend significant time looking at digital screens such as COMPUTER MONITORS, HDTV's, LAPTOPS, TABLETS, CELL PHONES etc, have a history of high blood pressure, diabetes, retinal problems or have a family member which suffers from retinal problems.

This state of the art procedure requires an addition 3 to 5 minutes of your time and there is an additional fee of only $39.00. **We strongly recommend that children also be scanned.****

Please check YES or NO below and sign.

_____ YES, I would like an examination including the Scanning Laser Retinal Imaging.

_____ NO, I understand the importance of Digital Retinal Imaging and understand this test would be in my best interest, but, at his time, I prefer the General Eye Examination only which will not include the Digital Retinal Imaging.

Signature: _____ Date _____

**Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out "certain eye diseases. In the latter case, you may be able to submit your bill for the retinal image or we will bill it on your behalf.

VISUAL FIELD SCREENING

Visual Field Analysis is a highly sophisticated, computerized system for assessing the neurological function of your vision. Unfortunately, routine eye examinations do not detect many diseases in their early stages. However, the Visual Field Analyzer is like having a "cat scan" specifically for the eye.

The Visual Field Analyzer can detect diseases such as pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to vascular problems and medications.

We strongly recommend that all of our patients over the age of 30 receive this evaluation. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems or have a family member which suffers from glaucoma or retinal problems.

This state of the art procedure requires an addition 10 to 15 minutes of your time and there is a nominal fee of $25.00.

Please check the appropriate box below and sign.

_____ I would like a Comprehensive examination including the Visual Field Screening.

_____ I understand the importance of the Visual Field Screening and understand this test would be in my best interest, but, at his time, I prefer the General Eye Examination only which will not include the Visual Field Screening.

Signature: _____ Date _____

Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out"certain eye diseases. In the latter case, you may be able to submit your bill for the visual field screening to your major medical insurance company for reimbursement. Other more comprehensive procedures may be found to be necessary and billed at a higher rate.

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CONTACT LENS EVALUATION INFORMATION

Contact lenses are medical devices controlled by the FDA and there is an expected "standard of care" required for contact lens wearers. We are dedicated to providing quality care to ensure your optimal comfort, vision, and most importantly, eye health.

It is not possible to determine in advance whether or not you will be a successful contact lens wearer, due to many factors that can influence your success. These factors include, but are not limited to: your expectations; unusual prescription; corneal shape; eyelid anatomy; manual dexterity; allergies; tear quantity; use of certain medications; willingness to return for follow-up care; improper lens care; and inability to follow lens care instructions or wearing schedule. Please discuss any factors you think may be a potential problem with the doctor before the lens fitting process.

There is a contact lens evaluation fee (starting at $90) which covers the initial evaluation to determine the most appropriate lenses and any additional contact lens related visits for up to 60 days. Additional fees will be charged in cases where extra follow-up visits or additional diagnostic lenses are required. In the event of any irritations or infections during the course of the fitting, the doctors will manage your eye(s) as a medical condition. The remainder of the contact lens evaluation will resume after the medical issue is resolved. We will provide a full lens care kit and instructions on caring for and wearing the lenses, including teaching insertion and removal of lenses.

A routine comprehensive eye exam is required in order to complete any contact lens fitting and evaluation. If it has been more than 3 months since your last routine eye exam, you will be required to have a complete comprehensive eye exam as well as a contact lens evaluation in order to be prescribed contact lenses.

Boxes of contacts can only be returned for an exchange if they are **unopened, unmarked, do not expire within 2 years, and in original condition, within 3 months. Professional fees and lens care products are non-refundable.**

We appreciate your selection of our office to provide your contact lens services. We will do everything possible to affirm your continued trust in our care. If you have any additional concerns or questions, please do not hesitate to ask our doctors' or courteous team members.

_____ _____
Patient's Name Date

_____
Patient Initial/Parent Initial if minor