OFFICE USE: EP NP GLX CLX PW NW PHOTO DFE RT APPT PW ID# VB:			
PATIENT INFORMATION AND RELEASE FORM			
Last name:		Today's date:	
First name:		Birth date:	
Employer:		Occupation:	
Email address:		Referred by:	☐ Online ad ☐ Online search (Google)
I am:	◯ Male ◯ Female		☐ Radio ☐ Friend/Other:
Mailing address:		City/State/Zip:	
Preferred number:		Phone type:	◯ Home ◯ Work ◯ Cell ◯
Secondary number:		Phone type:	◯ Home ◯ Work ◯ Cell ◯
We use phone calls, text and/or emails to remind you of your appointment. We will use the contact information you provide.			

MEDICAL AND OCULAR HISTORY **—IMPORTANT: THIS SECTION MUST BE COMPLETED FOR EACH VISIT—**							
Are you planning to get new glasses today?				◯ Yes ◯ No			
Are you planning to get new contact lenses today?				◯ Yes ◯ No			
Age of present glasses:				Age of present sunglasses:			
Date of last eye exam:				Name of doctor for last exam:			
Do you or any of your blood relatives (i.e., brother or sister, parents, grandparents) have any of these conditions?							
	Self	**Relative**	**None**		**Self**	**Relative**	**None**
Diabetes	◯	◯	◯	Glaucoma	◯	◯	◯
High blood pressure	◯	◯	◯	Cataracts	◯	◯	◯
Thyroid problems	◯	◯	◯	Retinal disease or detachment	◯	◯	◯
Heart disease	◯	◯	◯	Eye surgery	◯	◯	◯
Asthma	◯	◯	◯	Eye injury	◯	◯	◯
Cancer	◯	◯	◯	Other	◯	◯	◯
Do you see double?	◯ Yes ◯ No			Frequent headaches?	◯ Yes ◯ No		
Are you pregnant?	◯ Yes ◯ No			Eyes been dilated?	◯ Yes ◯ No		
Primary care physician:				If yes, year last dilated?			
Physician contact information:							
Please explain any positive findings noted above:							
Are you taking any eyedrops (prescription or over-the counter)? Please list:							
Are you taking any other medications (prescription or over-the counter)? Please list:							
Do you have any environmental, medication, or other allergies? If yes, please explain:							

PLEASE CONTINUE ON REVERSE SIDE ➔

RETINAL IMAGING AND EXAMINATION DISCLOSURE AND SELECTIONS:

All patients should receive a comprehensive health evaluation annually which includes dilation and photos. We believe that even patients with healthy eyes should be screened annually in order for the doctor to be able to compare the baseline images of healthy eyes with any future images that may detect disease. The doctor is able to get a much better view of the inside of the eye, resulting in a more thorough eye examination. **There are many conditions that can only be detected with a more thorough health evaluation, such as macular degeneration, glaucoma, hypertension, and diabetes.**

Initial below:	Options:
DECLINE ☐	**Option 1: I choose to have my retinal health evaluated with photos ($40 co-pay with insurance).** This procedure takes less than 3 minutes. There are no lasting side effects. This provides a permanent record of your retinal image. Knowing what the eye looked like when it was healthy is often the best way to detect if disease is starting. Your retinal photos can be compared with future photos to determine if any changes have occurred.
DECLINE ☐	**Option 2: I choose to have my eyes dilated. I am aware of the side effects of the drops and the additional time that will be added to my exam.** With dilation, eye drops are used to make your pupils larger. This procedure adds a minimum of 30 minutes to your eye exam. The effects of the drops usually last 5 – 6 hours, and cause blurred vision, especially up close. You will be sensitive to bright lights. If you do not have a pair of sunglasses, we will provide a disposable pair. The most common reasons for a dilated exam include: small pupils, trauma, lens opacities (cataracts), and symptoms such as floaters or flashes of light. A dilated exam is recommended to perform a complete and thorough eye exam. Some people find driving difficult after dilation. If you feel unsure or uncomfortable, we recommend that you have someone else drive you.

CONSENT, RELEASE, AND ACKNOWLEDGEMENT:

By my signature below, I consent to examination and treatment necessary for the care of the patient. I hereby authorize the release and transfer of any information required, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. I accept financial responsibility for all charges incurred, and acknowledge that payment is due at the time of service. I understand that submission of an insurance claim is not a guarantee of payment to the provider. If the insurance claim is denied or does not pay in full, I accept the financial responsibility for the balance. If my account is sent to collections, I understand there will be a 40% fee added. I accept fees associated with credit card disputes. **All exam fees are final (no refunds). I understand that I have 30 days from the original exam date to return for a recheck at no additional charge (excludes medical eye changes, such as diabetes or corneal change and contact lens over wear). After 30 days I will be responsible for a $49 fee, this applies up to 6 months from the original exam date. Due to the time involved and custom nature of eyewear, all sales must be paid in full before the order can be placed and all sales are final. Orders are submitted at the time of payment. Change orders are subject to 25% restocking fee. We want you to be happy with your eyewear purchase. I understand I have a 30 day period to report anything not to my satisfaction with my eyewear.**

Contact lens prescriptions are to be completed within 30 days of the initial exam and may be released once the doctor is satisfied with your lens fit and compliance. This, however, releases this office from any further responsibility with respect to your contact lens care.

I acknowledge that I have reviewed, am aware of, and may view these documents at jsaeyedocs.com or request a copy of:

1) **Financial policies.**
2) **Notice of privacy practices in compliance with HIPAA.**

I certify that I have read and fully understand the statements above.

Acknowledgement – type name for fillable PDF (parent or guardian if under age 18)	Date

Please save and email this completed form to: info@jsaeyedocs.com