WILDWOOD EYECARE
1545 Powers Ferry Rd., Suite 240, Marietta, GA 30067
Phone: 770-952-6412 Fax: 678-369-7212

PATIENT INFORMATION & HISTORY

Thank you for choosing our practice for your eye care needs. PLEASE PRINT as you complete this form and do not hesitate to ask for assistance if you have any questions or concerns. We look forward to serving you.

Name _____ **Nickname** _____ **Date** _____

Address _____**City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Birthdate _____ **Age** _____ **Social Security #** _____ **E-mail**_____

Please circle: Male / Female Married / Single **Occupation** _____ **# Computer hours/day** _____

Employer _____ **Employment Status**: Full-time / Part-time / Self-employed / Retired / Full-time Student

Vision Insurance _____ **Medical Insurance**_____ **Medical Doctor** _____

Primary Insured Member: **Name** _____ **Birthdate**_____ **SSN #** _____

Previous Eye Dr. _____ **Last Eye Exam** _____ **How did you hear about us?** Insurance/ Phone book/ Friend/ Other_____

List of Family Members: _____

Reason for visit: Glasses / Contact Lenses / Eye Infection / Eye Injury / Eye Health Exam / Referral / Other _____

Do you have any known **allergies** (medical or environmental)? □ No □ Yes _____

Are you taking any **medications**? □ No □ Yes _____

_____

You May Opt Out Of Completing The Next 3 Questions:
(This information is used to help us reach our meaningful use requirements for electronic health records)
Preferred Language (*Select One):* □ English □ Spanish □ Other:_____ □ Opt Out

Race: (*select One):* □ American Indian or Alaska Native □ Asian □ African American □ Hispanic
□ Native Hawaiian □ Other Pacific Islander □Caucasian □ Opt Out

Ethnicity (*Select One):* □ Hispanic or Latino □ Native Hawaiian □ Other Pacific Islander □ Not Hispanic/Latino □ Opt Out

Communication Preference *(Select One)***:** □Email □Telephone □Mail

Please check any of the following that applies to yourself or your immediate family members:

	Self	Family		Self	Family		Self	Family
Allergies	____	____	Blurred Vision	____	____	Anemia	____	____
Amblyopia / Lazy Eye	____	____	Burning / Stinging	____	____	Arthritis	____	____
Blindness / Vision Loss	____	____	Double Vision	____	____	Cancer	____	____
Cataracts	____	____	Dryness	____	____	Diabetes	____	____
Crossed eyes	____	____	Eye Pain/Soreness	____	____	Headaches	____	____
Eye Injury	____	____	Flashes of Light	____	____	Heart Disease	____	____
Glaucoma	____	____	Floaters / Spots	____	____	High Blood Pressure	____	____
Macular Degeneration	____	____	Foreign Body Feeling	____	____	High Cholesterol	____	____
Retinal Detachment	____	____	Itching	____	____	Kidney Disease	____	____
Retinal Disease	____	____	Tired eyes	____	____	Multiple Sclerosis	____	____
Red eyes	____	____	Watering / Tearing	____	____	Respiratory Problems	____	____
HIV Positive	____	____						

Other: _____

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Do you wear glasses? No / Yes How old are the present glasses? _____ What type? Single vision / Bifocal / Trifocal / Progressive /Readers

Do you wear contact lenses? No / Yes How old are your current contacts? _____ How often do you dispose your contacts? _____

What brand of contacts do you wear? _____ Do you sleep in them? No / Yes How many nights a week? _____

What solutions do you use? _____ Are you experiencing any problems with contacts? Dryness / Discomfort / Redness / Blurred vision

Are you interested in LASIK or other types of refractive correction? No / Yes If so, when? _____

Social History:
Do you currently smoke or use chewing tobacco? No / Yes

Do you use recreational drugs? No / Yes

STATEMENT OF FINANCIAL POLICY

As a service to you, this office offers several means of payment for the services and materials which you may require. It is customary to pay the Professional fees at the time of the examination, and to pay for any required materials (spectacles, contact lenses, special visual aids) and /or follow-up care by paying **50% on ordering and the balance on delivery.**
You are responsible for any co-pays, co-insurances, deductibles and other non-covered services or materials the day services are rendered. If you are being seen for any ongoing medical condition, co pays are due at each and every visit. Our office accepts cash, personal checks, debit cards, MasterCard, Visa, Discover and American Express.

Please note that there will be a **$25 charge for any returned checks.**
If we are not informed of insurance benefits before services are rendered, we will not be able to file your claim. Loss of benefits may result.

INSURANCE AUTHORIZATION

- I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered.
- I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me.
- I understand that my eye care insurance carrier may pay less than the actual bill for services and **I agree to be responsible for payment of all services rendered to me or my dependents.**
- I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health care practitioners.

I certify that I have updated and reviewed my health history, personal contact information and insurance information. Please sign and date below once per year.

X_____ Date _____
Patient Signature

X_____ Date _____
Patient Signature

X_____ Date _____
Patient Signature

X_____ Date _____
Patient Signature

X_____ Date _____
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DILATION

Evaluating the health of the back of the eye each year is a very important part of a comprehensive eye exam. We offer two different forms of this: Dilation Drops and Optos Retinal Imaging.

Dilation Drops: Drops are put in the eyes to enlarge the pupil to allow for a view into the back of the eye.

Optos Retinal Imaging: A quick and efficient way of monitoring your eye health without using drops. The Optos also allows the doctors to keep a digital photo of your eyes each year and may be used as a comparison in the future. The cost for this service is **$35.00** and not covered by any insurance.

SIGNATURE REQUIRED

________ I opt to have the Dilation Drops

________ I opt to have the Optos Retinal Imaging today for an **additional $35.00 charge**.
Certain conditions require dilation each year and would not qualify for Optos Retinal Imaging.

Patient Signature: ____ Date: ______________________

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Certain conditions require dilation each year and would not qualify for Optos Retinal Imaging.

Patient Signature: ____ Date: ______________________

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