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

PATIENT INFORMATION & HISTORY

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**_____

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

Medical Doctor _____ **Pharmacy**_____ **Pharmacy Phone #**_____

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

List of Family Members At Practice:_____

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 **(Please List)**_____

_____

Please check any of the following that apply to yourself:

Amblyopia / Lazy Eye	____	Retinal Disease	____	Cancer	____ what type?_____
Cataracts	____	HIV Positive	____	Diabetes Type I	____
Glaucoma	____	Anemia	____	Diabetes Type II	____
Macular Degeneration	____	Arthritis	____	Heart Disease	____
High Blood Pressure	____	Kidney Disease	____	High Cholesterol	____
Multiple Sclerosis	____	Migraines	____	Respiratory Problems	____ what type?_____
Other	_____				

Have you had any eye injuries or eye surgeries? _____ if so, please explain _____

Please check if any of your family members have the following:

Cancer	____	Hypertension	____
Diabetes Type I	____	Macular Degeneration	____
Diabetes Type II	____	Glaucoma	____

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

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

You May Opt Out Of Completing The Next 3 Questions:
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

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.

_____ I opt to have the Dilation Drops

_____ I opt to have the Optos Retinal Imaging today for an **additional $35.00 charge**.

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.

Vision plans only cover routine vision wellness exams, eyeglasses and contact lenses. Medical eye exams (the diagnosis and treatment of eye health problems) and additional procedures (i.e. fundus photos, visual fields, OCTs) are billed to medical insurance.

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 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 according the HIPPA Privacy Laws.

I certify that I have updated and reviewed my health history, personal contact information and insurance information.

Patient Signature: _____ Date: _____