



Today's Date: ___/___/___

PATIENT INFORMATION

Patient Name: (First) _____ (MI) _____ (Last) _____
 Preferred Name: _____ Male Female
 Date of Birth: ___/___/___ SSN#: _____ - _____ - _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone Preferred: _____ Work Preferred: _____ Cell Preferred: _____
 Occupation: _____ Employer: _____
 Email: _____
 Spouse's Name: _____ Date of birth: _____ Employer: _____

Right handed _____
 Left handed _____

INSURANCE INFORMATION

Your eye exam includes much more than just checking your vision. It is of the utmost importance to assure that your eyes are healthy and disease free. In order for Dr. Taylor and Dr. Hall to examine your eyes adequately it may be necessary to have additional testing performed during the exam or at another scheduled appointment. Dr. Taylor and Dr. Hall will discuss the nature and necessity of these tests with you before performing them. **These tests may incur additional fees which may not be covered under your Vision Insurance, but may be covered under your Medical Insurance.** Therefore, *even if you do not currently have vision insurance*, please fill out the information below concerning your Medical Insurance and bring your insurance card to the front desk. If you have any questions or concerns, please feel free to speak with a member of our staff. Thank you.

Vision Insurance <input type="checkbox"/> No vision insurance	Medical Insurance <input type="checkbox"/> No medical insurance
Name of insurance: _____ Insurance ID: _____ Group: _____ Are you the primary insured? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, skip section below) Name of insured _____ SSN _____ DOB _____ Employer _____ Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Check if address and contact info is the same as patient Street _____ City _____ State _____ Zip _____ Home Phone _____	<input type="checkbox"/> Check if medical and vision are the same. Name of insurance _____ ID _____ Group _____ <input type="checkbox"/> Check if the info below is the same as in the left column Name of insured _____ SSN _____ DOB _____ Employer _____ Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Street _____ City _____ State _____ Zip _____ Home Phone _____

PLEASE SIGN THE FOLLOWING STATEMENT WHICH ALLOWS US TO FILE A CLAIM WITH YOUR INSURANCE COMPANY:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the companies listed above and assign all insurance benefits directly to Dr. Christy Taylor/TaylorMade Eyecare & Optical. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions.

SIGNED: _____ DATE: _____

PATIENT COMMUNICATION OPT-IN ACKNOWLEDGEMENT

How would you best like to be contacted when your ordered items have arrived or for appointment reminders?

TEXT/EMAIL or VOICE

EYE HEALTH HISTORY

Date of Last Eye Exam: _____ Name of Eye Doctor or Location: _____

Interested in learning more about LASIK or other corrective surgical procedures? Yes No

Please mark any problems below, as best you can, that you are currently experiencing:

<input type="checkbox"/> Blurred Vision-Distance	<input type="checkbox"/> Crossed Eyes/Lazy Eye	<input type="checkbox"/> Dizzy Spells
<input type="checkbox"/> Blurred Vision-Intermediate	<input type="checkbox"/> Floaters	<input type="checkbox"/> Mucous Discharge
<input type="checkbox"/> Blurred Vision-Near	<input type="checkbox"/> Poor Night Vision	<input type="checkbox"/> Blind Spot(s) in Vision
Loss of Vision:	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Seeing Halos
<input type="checkbox"/> Temporary	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Constant	<input type="checkbox"/> Watery Eyes	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Strain
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Stye(s)
<input type="checkbox"/> Seeing Flashes	<input type="checkbox"/> Twitching Eyelid	

Please mark any of the following symptoms noticed after extended computer/device usage:

Blurred Vision Eyestrain Headaches Dry Eyes Watery Eyes Glare Sensitivity

Do you currently wear glasses? Yes No

If YES, do you wear them: Full-time Part-time

What type of lenses?

Single Vision *Distance Only* Single Vision *Near Only* Lined Bifocal Progressive

What do you like about your current glasses?

What would you change about your current glasses?

Do you currently wear contact lenses? Yes No

Please be aware that there is a contact lens fitting fee that may or may not be covered by your insurance. This fitting, by law, has to be updated every 12 months in order to have an active contact lens Rx and be able to order contact lenses.

If YES, please answer the following questions:

What brand or type of contact lenses do you wear? _____

How old are your current lenses? _____

How often do you replace your lenses? _____

What is your normal wear schedule? _____ hours/day _____ days/week

Are you having any problems with your current contact lenses?

Dries out easily Uncomfortable Blurry Far Vision Blurry Near Vision

What brand of solution do your lenses soak in at night? _____

Do your back-up glasses have your current Rx? Yes No I do not have back-up glasses.

If you **DO NOT** wear contact lenses, please mark any of the following statements that apply to you:

I have had LASIK or other corrective surgery

I have been told I can't wear contact lenses because I have astigmatism or reading problems

I have worn contacts but stopped due to comfort/vision problems

I have never worn contacts but would like more information

MEDICAL HISTORY

Name of PCP: _____ PCP's Phone: _____

Date of last physical: ___/___/___ Preferred pharmacy: _____ Pharmacy phone: _____

	Self	Mom	Dad	Brother	Sister	Son	Daughter
Cataracts	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____	_____	_____
Retinal Disease (Type _____)	_____	_____	_____	_____	_____	_____	_____
Crossed Eye/Lazy Eye	_____	_____	_____	_____	_____	_____	_____
Hepatitis (Type _____)	_____	_____	_____	_____	_____	_____	_____
Cancer (Type _____)	_____	_____	_____	_____	_____	_____	_____
Cancer (Type _____)	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____
Diabetes (Type _____)	_____	_____	_____	_____	_____	_____	_____
Heart Condition (Type _____)	_____	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____	_____	_____
Sleep Apnea	_____	_____	_____	_____	_____	_____	_____
Emphysema	_____	_____	_____	_____	_____	_____	_____
Lupus	_____	_____	_____	_____	_____	_____	_____
Thyroid Conditions	_____	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____	_____	_____	_____
Shingles	_____	_____	_____	_____	_____	_____	_____
Turned Eye	_____	_____	_____	_____	_____	_____	_____
Fibromyalgia	_____	_____	_____	_____	_____	_____	_____
Muscular Dystrophy	_____	_____	_____	_____	_____	_____	_____
Multiple Sclerosis	_____	_____	_____	_____	_____	_____	_____
AIDS/HIV+	_____	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____	_____

How long have you been treated for any of the above conditions? _____

Please describe any major surgeries/year performed (including any eye surgeries/procedures):

Do you smoke? YES NOT NOW Never

If YES, how do you smoke and how often? _____

Do you drink alcohol? YES NO If YES, how many drinks per week? _____

Are you pregnant? YES NO If YES, how many months? _____ Gestational diabetes? YES NO

If you are diabetic: How often do you check your glucose levels? _____

Today's glucose level: _____ Average glucose level: _____ A1C Level: _____ Date last A1C Taken: _____

ALLERGIES:

MEDICAL:

ENVIRONMENTAL/FOOD:

CURRENT MEDICATIONS:

Include over-the-counter AND prescription drugs:



ACKNOWLEDGEMENTS



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FINANCIAL POLICY

We are pleased to welcome you as a new patient. Our primary mission at TaylorMade Eyecare is to deliver the best and most comprehensive vision care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. This includes services provided for a patient who is a minor. The presenting parent is responsible. We prefer payment in full when ordering glasses or contacts. However, a deposit of 50% can be made to initiate the order. The remaining balance will be due at dispensing. Materials will not be released until payment is received in full.

To assist you with your vision care investment, we provide the following payment options:

1. Cash – includes money orders and personal checks.
2. Credit Cards – we accept the following credit cards as payment for treatment: Visa, MasterCard, Discover, American Express.
3. CareCredit* – patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits (Subject to credit approval):
 - o Flexible financing options
 - o No annual fees or prepayment penalties
 - o Quick and easy application
 - o Receive a credit decision almost immediately
 - o Start your recommended treatment immediately (subject to credit approval).

We are happy to offer these choices so that you can select a payment option that best fits your needs. Please ask if you would like more information on CareCredit so that you can make an informed decision about which payment option you prefer.

We are panel providers and accept assignment on several vision plans. This means that at the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. As a courtesy to you, we will bill and receive payment directly from your insurance company for covered services. **You will be responsible for any remaining balance.**

We make no claim to know what services your insurance covers. Your insurance policy is a contract between you and your insurance company—we are NOT a party to that contract. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. **It is your responsibility alone to know what services may or may not be covered by your insurance.** We encourage you to refer to your benefits manual if you have questions about covered services. In addition, be aware that some and perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. Finally, in the event you provide incorrect insurance information that delays payment, you may be asked to pay full billed charges and seek reimbursement from your insurance provider directly. By signing below you certify that you have coverage with the insurance companies you provided to us and assign all insurance benefits to Dr. Christy Taylor as well as authorize the doctor to release all information necessary to secure payment of benefits, as well as the use of this signature for all insurance submissions.

CONSENT TO TREATMENT

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, or pre-test findings, the Doctor may find it necessary to bill your exam MEDICALLY as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and will be subjected to their specific co-pays, deductibles, and co-insurance. In the event you want a routine examination for your eyeglasses or contacts lens prescription, I understand it is my responsibility to immediately inform the Doctor so that they can refer me to the appropriate Specialist for any medical concerns.

HIPAA COMPLIANCE & RELEASE OF INFORMATION

My signature below indicates that I have received, reviewed, and understand my right to privacy under HIPAA guidelines. At your request, a copy will be made for you.

I have received a copy. I waived my right to a copy.

CONSENT OF ACKNOWLEDGEMENTS

I have read the "Financial Policy", "Consent to Treatment", and "HIPAA Compliance and Release of Information" as the Patient, or the Patient's Authorized Representative, or general Agent for the purpose of signing this document, and do hereby accept it's terms.

Patient Name (Please print): _____ Date of Birth: ____/____/____

Patient/Guardian Signature: _____ Today's Date: ____/____/____



Retinal Exam

DR. TAYLOR & DR. HALL RECOMMEND THAT EVERY PATIENT HAVE THE OPTOMAP IMAGE TAKEN.

Please take a moment to read more about this amazing technology below:

At TaylorMade Eyecare & Optical we pride ourselves on providing our patients with the best possible standard of care. The **optomap® Retinal Exam** is a non-invasive procedure that takes an image of your retina that allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling our doctors to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Our doctors strongly believe that the optomap® Retinal Exam is an essential part of your comprehensive eye exam and we prescribe it for all of our patients once per year.**

If you would like to have **optomap®** images taken today for review with your doctor during your examination, **the fee would be \$39.00.** This procedure is generally a non-covered service by your insurance, unless being used to actively follow disease. **If you have a disease that is actively being followed by our doctors, (ie: diabetes, etc) you may need to have BOTH the Optomap AND dilation (at which point, both will be filed through your medical insurance). Please ask if you have questions.**

At the doctor's discretion, this procedure can replace the need for a dilated exam.

___ **I ELECT** to have an Optomap Digital Retinal Scan of my retina and **agree to pay the \$39.00 fee.**

___ **I DECLINE THE OPTOMAP SCAN AND CHOOSE TO BE DILATED TODAY.** I understand that my vision will be slightly blurry after dilation and I will be light sensitive for 3-4 hours. (Dilation is covered under all insurance plans with your copay.) **FYI: We do not recommend dilation if you are in any stage of pregnancy.**

___ **I DECLINE BOTH** the Optomap Scan and dilation. I understand that the potential for partial or total loss of vision may exist due to undetected eye disease. I understand that if I had chosen either of the above options, our doctors would have a greater chance of detecting any potential disease or condition. Therefore by signing this, I release Dr. Christy Taylor and associates from any liability resulting from failure to diagnose or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

Signature

Print Name

Date

FOR OFFICE USE ONLY:

+ =

Ins

ex 2nd ct fit fr le ct

BP

Systolic

Diastolic

HR

IOP

OD OS