Today's Date: ____/____/____

To be used if patient is a MINOR

PATIENT INFORMATION

Patient's Name:____ Preferred Name:_____________________
Date of Birth: _____/_____/_____ Male: ____ Female: ____ Home Phone:_____________________________
Address: ____ City:_______________State: _____ Zip:__________
Parent(s) Names:
Parent:____ Cell Phone:_________________________
Family Email Address:____

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 ☐ No vision insurance	**Medical Insurance** ☐ No medical insurance
Name of insurance:______________________________________ Insurance ID:_________________________Group:____________ Are you the primary insured? ☐ Yes ☐ No (if yes, skip section below) Name of insured____ SSN________________________________ DOB_______________ Employer____ Relationship to insured ☐ Spouse ☐ Dependent ☐ Check if address and contact info is the same as patient Street____ City__________________________State______Zip____________ Home Phone____	☐ Check if medical and vision are the same. Name of insurance______________________________________ ID_____________________________ Group_________________ ☐ Check if the info below is the same as in the left column Name of insured____ SSN________________________________ DOB_______________ Employer____ Relationship to insured ☐ Spouse ☐ Dependent Street____ City_________________________State________Zip____________ Home Phone____

PLEASE SIGN THE FOLLOWING STATEMENT WHICH ALLOWS DR. TAYLOR TO FILE 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?

☐ TEXT/EMAIL or ☐ VOICE

TO ☐ MOM or ☐ DAD?

EYE HEALTH HISTORY

Date of Last Eye Exam: ___________ Name of Eye Doctor or Location:_________________________________

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

___Blurred Vision-Distance
___Blurred Vision-Intermediate
___Blurred Vision-Near
Loss of Vision:
   ___Temporary
   ___Constant
___Migraines/Headaches
___Light Sensitivity
___Seeing Flashes

___Crossed Eyes/Lazy Eye
___Floaters
___Poor Night Vision
___Itchy Eyes
___Red Eyes
___Watery Eyes
___Dry Eyes
___Burning Eyes
___Twitching Eyelid

___Dizzy Spells
___Mucous Discharge
___Blind Spot(s) in Vision
___Seeing Halos
___Double Vision
___Eye Injury
___Eye Strain
___Stye(s)

While doing near work of any kind (including reading, digital device, tablet usage, or computer work):

Have you noticed any squinting or leaning in/out?___ Avoiding near work all together?___

Double vision/over lapping words on page?___ Words running together on the page?___

Trouble keeping attention centered on reading?___

Head tilts or one eye is closed or covered while reading?___

After extended near/computer/video game use have you noticed any of the following?:

___Blurred Vision ___Eyestrain ___Headaches ___Dry Eyes ___Watery Eyes ___Glare Sensitivity

How many hours a day is the child using technology? ____

My child's favorite type of tech: ☐ PC/Laptop ☐ Tablet ☐ Handheld Device

Does the minor currently wear contact lenses? ____Yes ____No

If NO, are they interested in being fitted with them? ____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 has to be updated every 12 months to have an active contact lens Rx.

If YES, please answer the following questions:

What brand or type of contact lenses do they wear?_________________________

How old are their current lenses?_____________________________

How often do they replace their lenses?___________________________________

What is their normal wear schedule? ____hours/day ____days/week

Are they having any problems with their contact lenses?
____Dries out easily ____Uncomfortable ____Blurry Far Vision ____Blurry Near Vision

What brand of solution do their lenses soak in at night?__________________________________

MEDICAL HISTORY

Name of pediatrician:____ Pediatrician's Phone:___________________________

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

If child is diabetic: How often do they check their 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:

____

____

____

	Self	Mom	Dad	Brother	Sister	Son	Daughter
Cataracts	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____	_____	_____
Retinal Disease (Type___________)	_____	_____	_____	_____	_____	_____	_____
Crossed Eye/Lazy Eye	_____	_____	_____	_____	_____	_____	_____
Hepatitis (Type_____)	_____	_____	_____	_____	_____	_____	_____
Cancer (Type_________________)	_____	_____	_____	_____	_____	_____	_____
Cancer (Type_________________)	_____	_____	_____	_____	_____	_____	_____
Cancer (Type_________________)	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
Diabetes (Type___)	_____	_____	_____	_____	_____	_____	_____
Heart Condition (Type___________)	_____	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____	_____	_____
Emphysema	_____	_____	_____	_____	_____	_____	_____
Lupus	_____	_____	_____	_____	_____	_____	_____
Thyroid Conditions	_____	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____	_____	_____	_____
Shingles	_____	_____	_____	_____	_____	_____	_____
Turned Eye	_____	_____	_____	_____	_____	_____	_____
Fibromyalgia	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
AIDS/HIV+	_____	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____	_____

How long has the child been treated for any of the above conditions?

____

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

____

____

ACKNOWLEDGEMENTS

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):
   - Flexible financing options
   - No annual fees or prepayment penalties
   - Quick and easy application
   - Receive a credit decision almost immediately
   - 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 immediate 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 **opto**map® **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 opto**map® **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 **opto**map® 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		HR		IOP		
	Diastolic					OD	OS