STYLEYES

exams with care
frames with flair

Ms. Miss Mrs. Mr. Dr. PhD _____ Date of Birth: _____

Address: _____ Home Ph: _____

City/State/Zip: _____ Work Ph: _____

Email: _____ Cell Ph: _____

Parents' name (if minor): _____ ☐ Single ☐ Married

Employer: _____ Occupation: _____ ☐ Full-time ☐ Part-time ☐ Full-time Student

Vision Insurance Co.: _____ Subscriber: _____ DOB: _____

Medical Insurance Co.: _____ Subscriber: _____ DOB: _____

Primary care physician: _____ Phone: _____

Hobbies, special vision needs: _____

I wear glasses: ☐ yes ☐ no I have had laser corrective surgery: ☐ yes ☐ no Interested in LASIK? ☐ yes ☐ no

I wear contact lenses: ☐ yes ☐ no Type: _____ I replace my contacts every: _____

When was your last eye exam? _____ Name of previous eye doctor: _____

Referred by: _____ ☐ Doctor ☐ Friend ☐ Family ☐ Insurance Co. ☐ Advertisement

Due to the Health Insurance Portability and Accountability Act your initials & signature are required below

Initials:

☐ I authorize any holder of medical information about me to release to my insurance company or its agent any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized services be made on my behalf to StylEyes. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance company.

OR

☐ I decline the above information release and am solely responsible for fees. I understand that fees are due at time of service.

☐ I authorize any holder of medical information about me to release and/or request my medical information with other health care professionals for the purpose of consultation and referral as appropriate for my health care.

☐ I have been provided the StylEyes Privacy Policy. [You may request a copy for your records]

Signature _____ Relationship to patient _____ Date _____

Digital Retinal Imaging

Our office utilizes state-of-the-art equipment including a digital retinal camera. This camera provides digital images of your retina and aids our doctors in early detection and diagnosis of many eye diseases. Our doctors highly recommend this procedure for all patients, and it is especially important for all persons experiencing flashes, floaters, headaches, decreased vision, or previously diagnosed with hypertension, diabetes, or family history of glaucoma or macular degeneration. Digital retinal imaging is generally not covered by vision insurance, but IS billable with a medical condition under your medical insurance. You are responsible for any fees not covered by your insurance ($29). Unless you decline below, digital retinal imaging will be performed.

Against my doctor's advice, I decline digital retinal imaging: _____ (Signature)

STYLEYES *exams with care frames with flair*

PATIENT NAME: _____ DATE: _____

GENERAL HEALTH INFORMATION SHEET

Please list any medications: _____

_____

_____

_____

_____

Please list any allergies (medical & general): _____

_____

_____

_____

Do any of the following conditions apply to you:

_____ Constitutional (fever, weight change)	_____ Ear/Nose/Mouth/Throat	_____ Cataracts
_____ Lazy eye or eye turn	_____ Skin Condition	_____ Cancer
_____ Stomach or Gastrointestinal	_____ Kidney or Liver	_____ Lung or Respiratory
_____ Asthma	_____ Diabetes	_____ Stroke
_____ Heart condition/disease	_____ High blood pressure	_____ High cholesterol
_____ Psychological	_____ Blood disorder	_____ Headaches
_____ Multiple sclerosis	_____ Arthritis or joint	_____ Thyroid
_____ Alcohol: □ light □ mod □ heavy	_____ Immune deficiency	_____ Pregnant
_____ Tobacco: □ light □ mod □ heavy	_____ Macular degeneration	_____ Glaucoma
_____ Drug use: □ light □ mod □ heavy	_____ Retinal detachment	_____ Dry eye

If you indicated any of the above conditions apply to you, please explain and list treatment:

_____

_____

Please list any other health conditions: _____

_____

_____

Does your family history include any of the following? If yes, what is their relationship to you?

	Relationship:		Relationship:
_____ Glaucoma	_____	_____ High Blood Pressure	_____
_____ Cataracts	_____	_____ Heart Disease	_____
_____ Macular Degeneration	_____	_____ Diabetes	_____
_____ Retinal Detachment	_____	_____ Thyroid Condition	_____
_____ Blindness	_____	_____ Other	_____

Signature: _____ Relationship to patient: _____