Eyes of Chicago

_____ Mr. _____ Mrs. _____ Ms. _____ Dependent Child

E-Mail:
Preferred method of recall: ☐ Email ☐ Post card

Patient's Last Name	First Name	M.I.	☐ Male ☐ Female ☐ Other	Birth Date

Home Address	City	State	Zip
Best Phone Number: ( )	Employer:	Social Security #	

☐ **Yes, I am the Primary member** of the insurance policy. ☐ **No, I am not the Primary member**.	**Primary Member's** First & Last Name: ______________________________ Date of Birth: ____________________	Patient Relationship to the Subscriber: I am the ☐ Spouse, ☐ Dependent Child
Referred By:	Medical Insurance ________________	Vision Insurance ______________

Date of last vision exam: ___________________ By Dr. ________________________ Age of Current Glasses: ____________________________________

Date of Eye Surgery:___________________ Date of last medical exam:____________________ Primary Physician:______________________________

Do you smoke cigarettes? No Yes

Are you currently Pregnant? No Yes

Are you struggling reading up close and/or seeing far away? List when/where:____

List Medications & Vitamins you are taking? ____

Are you allergic to any medications? No Yes, name:____

Experiencing headaches, migraines, floaters? No Yes, when:____

Are you experiencing any night vision problems? No Yes, how often: ____

Do your eyes ever feel dry, itchy, tear up frequently? No Yes, list:____

Check **Self and/or Relative** if any of these conditions apply to yourself and/or a relative

	Self	Relative		Self	Relative	
Glaucoma	______	________	High Cholesterol	______	_______	Other:______________________
Cataracts	______	________	Macular Degeneration	______	_______	
Diabetes	______	________	Retinal Disease	______	_______	
Heart Disease	______	________	Thyroid Disease	______	_______	
Hypertension	______	________	Retinal Detachment	______	_______	

Contacts Lens Information.

**For the safety of your health and required by law, contact lens prescriptions are valid for one year and must be renewed annually to order contacts.*

Identify the contact lens you currently wear? ____

Are you allergic to any particular contact lens solution? No Yes, identify:____

Do you sleep in your contacts? No Yes

Release of Information

You may release any/and all information to the following members (Name/Relationships):

____

Insurance Verification

You are **financially responsible** for all services, product charges, should your insurance consider any of these charge to be non-covered expenses. **Insurance** is not a guarantee of payment. Any and all refunds are processes at the end of each month.

Insurance coverage is the patient's responsibility. For any services other than routine eye coverage, we will bill your insurance company. If for any reason the claim is denied, you are responsible for payment in full.

Insurance must be presented at time of service. We will no longer be able to process any insurance and/or discounts at a later date.

______

Initial

Notice of Privacy and Policy Practices

I acknowledge and have been made aware that Eyes of Chicago has a Notice of Privacy and Policy Practices handbook, a copy which has been offered for inspection if requested.

______

Initial

Responsibility Statement/Acknowledgment of Privacy Practices

This form permits our office to computer generate, electronically file and/or personally file any and all claims pertaining to any any visual insurance claim.

I, the patient, and/or responsible party, give permission to Eyes of Chicago, to release any information necessary to file for my insurance. I am fully aware that neither confidential information, nor any other information not routinely needed to filing my insurance will be release.

______ ______________________________

Date **Please Print Patient's Name**

____

Signature of Patient/Guardian

Digital Retinal Imaging

Dear Patient,
A computerized instrument now allows us to provide you with a MORE THOROUGH medical analysis of your eye. The digital retinal imaging camera takes digital pictures of the retina (nerve layer inside the back of your eye). This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, hypertensive retinopathy, and other sight threatening conditions. The pictures are stored in our database and will be used to compare with future images to observe for any future changes in the health inside your eyes.

The doctor strongly recommends that ALL patients have this procedure performed routinely. If you are **40 years and older, the doctor recommends YEARLY** photos. It is especially important for people who have:

1. Headaches
2. Diabetes
3. High blood pressure
4. High cholesterol /triglycerides
5. 40 years of age and older
6. Family history of Glaucoma, Macular Degenertaiton, and or blindness
7. Family history of Diabetes or High blood pressure
8. NEW PATIENTS

Medical and Vision insurances DO NOT pay for routine photos. **The charge for routine photos is $39**. If there is a medical diagnosis found, your medical insurance may pay for this procedure. This usually requires a written interpretation or report by the doctor and additional fees will be submitted to your insurance company. The doctor will NOT know prior to your exam if there is a medical diagnosis that would allow for insurance submission.

Please check the appropriate line and sign at the bottom.

___ Yes, I would like the imaging procedure performed.
___ No, I decline to have the imaging procedure performed.

____
Signature of Patient (or parent if under 18 years old)

____ Date ________________
Patient Name (printed)