

Eyes of Chicago



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

E-Mail: _____

Email annual appointment reminder? Yes or No

Patient's Last Name		First Name		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Birth Date	
Home Address			City		State		Zip
Best Phone Number: ()			Employer:		Social Security #		
<input type="checkbox"/> Yes, I am the Primary member of the insurance policy. <input type="checkbox"/> No, I am not the Primary member.		Primary Member's First & Last Name: _____ Date of Birth: _____			Patient Relationship to the Subscriber: I am the <input type="checkbox"/> Spouse, <input type="checkbox"/> 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 use tobacco products? No Yes, _____ pack per day

Do you drink alcohol? No Yes, _____ drinks per week

Do you intake any other substance(s)? No Yes

Are you currently Pregnant? No Yes

List Medications & Vitamins you are taking: _____

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

Do you have seasonal or environmental allergies? No Yes, list: _____

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

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

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

	Self	Relative		Self	Relative	Other _____
Glaucoma	_____	_____	High Cholesterol	_____	_____	
Blindness	_____	_____	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 coverage** is the patient's responsibility. If for any reason the claim is denied, you are responsible for the payment in full. **Insurance** is not a guarantee of payment. Any and all refunds are processed at the end of each month

Insurance must be presented at time of service.

We will not 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 may be given 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 medical and/or vision 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 for filing my insurance will be released.

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:

- Diabetes
- Family history of Glaucoma, Macular Degeneration, and or blindness
- Family history of Diabetes or High blood pressure
- Headaches
- High blood pressure
- High cholesterol /triglycerides
- 40 years of age and older
- NEW PATIENTS

The charge for routine photos is \$39.

If there is a medical diagnosis found, your medical insurance may pay for this procedure; however it is not a guarantee of coverage. 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.

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)