PATIENT STATUS: ☐ NEW ☐ EXISTING

APPOINTMENT DATE: ______

E-Mail Address:

PATIENT'S NAME: (LAST, FIRST, M.I)

Address:

City: State: Zip:

Date Of Birth: / / Home Phone: ( ) Work Phone: ( )

Patient's Social Security Number Sex: ☐ M ☐ F

			-			-				

PATIENT'S EMPLOYER:

INSURED'S NAME: (LAST, FIRST, M.I) If not self, Complete Insured Information Below

Address:

City: State: Zip:

Date Of Birth: / / Home Phone: ( ) Work Phone: ( )

Primary Insurance:

Subscriber I.D # or SSN

Patient's Relationship To Insured:
☐ Self ☐ Spouse ☐ Child Other ______

Vision Insurance: ☐ VSP ☐ EyeMed ☐ Davis Other ______

Section 1 – Medical Information

1. Date of last Eye Examination: ______
2. What is the reason for your Examination Today? ______
3. Do you currently wear glasses? ☐ Yes ☐ No

   If Yes, Would you like your lenses to be (check applicable)
   ☐ Thinner ☐ Lighter ☐ Impact Resistant ☐ Glare Free
   ☐ Sensitive to Light Conditions (Transitions)
4. Do you wear glasses for:
   ☐ Distance ☐ Reading ☐ ConstantWear ☐ Don't Wear Glasses
5. Do you currently wear contact lenses?
   If No, Would you be interested in contact lenses? ☐ Yes ☐ No
   If Yes, What type of lenses are you wearing?
   ☐ Hard Lens ☐ Soft Lens
6. Are you taking any type of medication or pills? ☐ Yes ☐ No
   If yes, Please explain: ______
7. Are you Allergic to any medications? ☐ Yes ☐ No
   If yes, Please explain: ______
8. Have you ever had: ☐ An eye injury ☐ Eye surgery ☐ Spots
   ☐ Vision Training ☐ Floaters ☐ Double Vision
9. Do you have or had any of the following?
   ☐ High Blood Pressure ☐ Lazy Eye ☐ Diabetes
   ☐ Glaucoma ☐ Macular Degeneration
   ☐ Cancer ☐ Heart Disease Other: ______
10. Has anyone in your family had:
    ☐ High Blood Pressure ☐ Lazy Eye ☐ Diabetes
    ☐ Glaucoma ☐ Macular Degeneration
    ☐ Cancer ☐ Heart Disease Other: ______
11. Would you like to have an iWellness test performed?
    The cost is an additional $39 and helps us keep better track of your eye health using the latest imaging technology.
    ☐ Yes ☐ No
    (no dilation is required for this test. We will let you know if covered by your insurance.)

Section 2 – IMPORTANT! Please Read and Sign

1. Our vision center provides spectacle lenses that meet or exceed American National Standards Z80.1/Z78.1 and FOA requirements 21 CFR 801.410 for impact resistance. No lens material available today is unbreakable or shatterproof. Of all the materials that lenses are made from, Polycarbonate, Plastic and Glass, **POLYCARBONATE HAS BEEN RECOGNIZED AS THE MOST IMPACT RESISTANT.**
2. **DILATED EYE EXAMINATION INFORMATION** Dilation is an auxiliary medical procedure, which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye) With dilation the doctor has the opportunity to evaluate and diagnose eye health problems before symptoms occur. It is recommended that all patients receive a dilation every 2 to 4 years, unless certain conditions require closer monitoring. Some patients may experience light sensitivity and blurred vision for 2-6 hours. If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You should be able to drive after the procedure, but if you feel more comfortable being driven, please make arrangements to do so.

   In rare instances, patients may experience pain. If this should occur, please seek medical attention immediately. **Please advise our optometrist if you are pregnant or nursing at the time.** If you have any other questions regarding dilation please consult our doctor for additional information.
3. **DEPOSIT POLICY** Payment for eye examinations, contact lens examinations, contact lens checks and continuing eye care plans is required at time services are provided. A minimum deposit of 50% is required to order eyeglasses or contact lenses.
4. **INSURANCE DEPOSIT POLICY** 50% of patient balance is required after insurance benefit is applied.
5. **I accept financial responsibility for any unpaid balance not covered by my vision care program for services rendered to myself, my spouse, and/or my dependents. I also authorize the release of any information relating to this claim.**

   Patient's Signature ______

   Guardian Signature ______
6. **I authorize payment of medical benefits to the undersigned physician or supplier for services.**

   Patient's Signature ______

   Guardian Signature ______

FOR DOCTOR USE ONLY

PROCEDURE CODES		ICD. 10 CODES	
1. 92004	2. 92014	1. H52.03	2. H52.13
3. 92002	4. 92012	3. H52.4	4. H53.009
5. 92015	6. Follow Up	Other:	

Patient Name: ______________________ DOB: __________

Dr. __________ Date __________
LEE __________ Tech __________
CL Type: DW EW TORIC RGP DISP
CL Brand & Rx __________
LTW OD ______ OS ______ AWT ______
Comfort: good poor Vision clear blurred
Solutions: Renu MP Optifree

CC: __________

VA:

	Far Unaided	Far Aided	Near Unaided	Near Aided
OD:	20/	20/	20/	20/
OS:	20/	20/	20/	20/
OU:	20/	20/	20/	20/

IOP: NCT GAT OD ______ mm/Hg
Time: __________ OS ______ mm/Hg
1 gt Fluress @

Color Vision: OD ____/7___ OS ____/7___
Ishihara
Stereopsis ________ see Binocular: Yes No
Phoria (H)______ XP / EP (V) _____ RH / LH

Hab Eg Rx	Sphere	Cyl	Axis	Add
OD			x	+
OS			x	+

Age Hab Rx: __________

Auto-Refraction (see attached)

Static Cycloplegic
OD:
OS:

CT: UCT ______ CF: OD FTFC Other: ______
c sc ACT ______ CF: OS FTFC Other: ______

EOM'S OD FROM Other:______
EOM'S OS FROM Other:______

PUPILS:

	Dim	Light	Reaction
OD	______ -	______	ERRLA ______
OS	______ -	______	ERRLA ______

RAPD: POS NEG OD OS

CL RX	SPHERE	CYL	AXIS	BC	DIA	BRAND	OTHER
OD							
OS							

SUBJ RX	SPHERE	CYL	AXIS	PRISM/BASE	VA	ADD	VA
OD					20/ ___		20/ ___
OS					20/ ___		20/ ___

EG RX	SPHERE	CYL	AXIS	PRISM/BASE	VA	ADD	VA
OD					20/ ___		20/ ___
OS					20/ ___		20/ ___

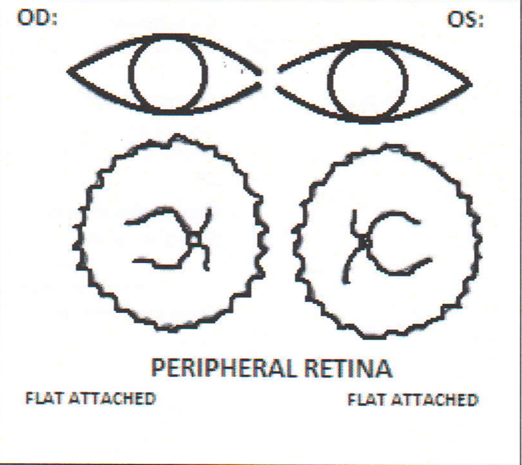
Check @ Dispensing ☐ NRA/PRA: __________ BCC: __________

KERATOMETRY MANUAL AUTOMATED (SEE ATTACHED)

OD ______ / ______ @ ______ / ______ MIRES Clear Dist.
OS ______ / ______ @ ______ / ______ MIRES Clear Dist.

Slit Lamp Examination:

OD	OTHER		OS	OTHER
CL	______	TEARS	CL	______
CL	______	LIDS/LASHES	CL	______
CL	______	CORNEA	CL	______
Q	______	PAL CONJ	Q	______
Q	______	BUL CONJ	Q	______
D/Q	______	ANT CHAMBER	D/Q	______
FLAT	______	IRIS	FLAT	______
CL	______	LENS	CL	______
CL	______	ANT VIT	CL	______
1 2 3 4 4+		ANGLE EST.	1 2 3 4 4+	



Fundus Examination: DO BIO 28D 20D 90D 78D MIO

OD	OTHER		OS	OTHER
NORM CAL 2/3	______	VESSELS	NORM CAL 2/3	______
	______	A/V		______
CL	______	BACK GROUND	CL	______
CL	______	MEDIA	CL	______
+ FLR	______	MACULA	+ FLR	______
FLAT NORM CL	______	POST POLE	FLAT NORM CL	______
	______	VITREOUS		______
DISTINCT	______	DISC MARGINS C/D RATIO	DISTINCT	______

Dilation @ __________ Patient Refused
.5% Opthetic 1% Tropicamide Paramyd
2.5% Phenylephrine 1% Cyclopentolate
Other: __________
Patient R/S

ASSESMENT: Hyperopia (H52.03) Myopia (H52.13) Astigmatism (H52.209) Presbyopia (H52.4) Amblyopia (H53.009)
ADDITIONAL DIAGNOSIS __________; __________; __________

PLAN:

Discussed:		RTC:	
Astig & Va	Torics		
Poor Cand	RGP's	1D	2D
Presbyopia	DW only	1W	2W
Near Va	Decrease	1M	2M
Refer MD	WT	3M	6M
Rec. B/U	MWT 2wks	1Y	2Y
SPECS			

DIAGNOSTIC TESTS:
☐ VISUAL FIELD ☐ OCT ☐ FUNDUS PHOTO ☐ __________

Doctor Signature: ______________________ Date: __________

PATIENT FINANCIAL AGREEMENT, PRIVACY NOTICE, PATIENT RIGHTS, FINANCIAL DISCLOSURE AND ADVANCE DIRECTIVES

(EYES ON THE JOB)

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1. I understand that the fees charged are to determine the health of my eyes.
   Prescriptions for glasses and contact lenses are included in the evaluation fee.
2. I understand and accept the privacy statement for the Institute as posted on our website and that I can obtain a copy upon request.
3. I will pay reasonable attorney's fees and collections expense if my account is referred to an attorney for collection
4. I am responsible for my deductible, co-payment and the portion not covered by my insurance. My doctor will bill my insurance and I know that I am responsible for my doctor's bill if my insurance fails to pay for any reason.
5. I authorize my doctor and whomever he/she designates to act as my attorney in fact to collect from my insurance directly and to go through any appeal process needed to receive payment.
6. I instruct and order my insurance company to pay by check made out and mailed directly to my doctor. If my current policy prohibits direct payment, I hereby order my insurance company to make the check out to my name and mail it to my doctor.
7. A copy of this assignment shall be considered as effective and valid as the original.
8. I voluntarily authorize the release of all my health information including any information about sensitive conditions to any insurance company, adjustors, attorneys or other doctors involved in this case. Records that may be released include all information regarding my health history, hospitalization, tests and outpatient care, including, but not limited to: drug alcohol or substance abuse, mental health or developmental disabilities, sickle cell anemia, birth control and family planning, sexually transmitted disease, HIV/AIDS, tuberculosis, and genetic diseases or tests.
9. I authorize my doctor to initiate a complaint to the appropriate agency for any reason on my behalf using regular or electronic mail.
10. The Florida law states that any person who has a paid service within 72 hours of a free service or discounted offer has the right to refuse payment. I understand the law and by signing below I voluntarily and irrevocably wave my right to request a refund for any paid services related to a free or discounted offer. I understand that if I do not wish to waive my right I have the option to have any paid procedure, such as a surgery, after the initial 72 hours from the offer have lapsed.
11. I authorize payment of my deductible and co-payment directly from my credit card.
12. I certify that I am not enrolled in an any insurance or plan with which the doctors of this institute do not participate, and if I am, I understand that I am responsible for the doctors' and facility charges
13. I understand that there are no refunds for services provided
14. I have received verbal and written notification about Patients Rights and Responsibilities, Advance Directives and Disclosure of Physician Ownership in advanced of the date of any scheduled procedure.
15. I consent to my doctor obtaining my Medication History from third party payers, pharmacies and any other location where it may be.

☐ The patient cannot read the consent. I read it to the patient who verbalized understanding. I am signing as a witness.
☐ The patient did not sign because ▶
☒ The patient received written information.
 Patient, Parent , Responsible Adult, Agent or Representative

EYES ON THE JOB

NAME ______________________________ DATE ____________

POLICY REGARDING GLASSES

I have tested my prescription & I like it.

Measuring the eyes to prescribe glasses or to determine your best vision and the health of your eyes is not covered by most of the insurance plans and the patient is responsible for paying the refraction.

The prescription for the glasses is made based on the answers obtained from the patient during the exam.

For glasses covered by the insurance

I understand that my insurance will be billed, that I cannot cancel this order, nor purchase the glasses elsewhere using my insurance.

1. I have been informed that there are frames available at the optical that I can purchase at no extra charge.
2. I know that if I elect to purchase deluxe frames which are more expensive than the standard frames I am responsible for the difference in price.

Eyes On The Job Warranty (EOTJ):

If the glasses from EOTJ, EOTJ will make any needed changes to the lenses at no charge for one time only as long as:

1. In the first two months after purchasing the glasses you have worn the glasses for at least three weeks and you do not adapt,
2. there is a change in the prescription in less than three months,
3. the glasses were ordered more than 30 days after an eye surgery, since the prescription normally changes during the healing process
4. you order a similar lens when making a change. If you decide to upgrade to a better lens or design, you are responsible for the difference in price

The patient, not EOTJ, is responsible for payment to any optical outside EOTJ for a change in the prescription.

By signing below I certify that I tested the prescription for the glasses, I like them and I approve them.

- ☐ I wish to order my glasses from the EOTJ Optical.
- ☐ I wish to order my glasses at an optical outside EOTJ.

Patient Signature:

Witness Signature:

POLITICA DE SOBRE ESPEJUELOS

Me han probado mi receta y me gusta.

Medir la vista para recetar espejuelos o para determinar su mejor vision y la salud de sus ojos no es cubierto por la mayoria de los seguros medicos y el pago de la misma es la responsabilidad del paciente.

La receta de los espejuelos se hace basada en las respuestas obtenidas de los pacientes durante el examen de la vista.

Para espejuelos cubiertos por el seguro

Entiendo que se le cobrará a mi seguro, que no puedo cancelar esta orden, ni ordenar los espejuelos en otra óptica usando mi seguro.

1. Se me ha informado que hay marcos en la óptica que puedo comprar y que son cubiertos por el Medicare.
2. Se que si elijo un marco de marca (deluxe) que es de mayor precio que los marcos estándar. Soy responsable por pagar la diferencia de precio.

Garantía de Eyes On The Job (EOTJ) :

Si compra los espejuelos en EOTJ, nosotros le haremos cualquier cambio a los cristales sin recargo una vez, siempre que:

1. En los primeros dos meses después de haber comprado los espejuelos si usted use los espejuelos por lo menos tres semanas y no se adapte, o
2. haya un cambio de la receta en menos de tres meses
3. los espejuelos sean recetados más de 30 días después de una operación de ojos, ya que la receta normalmente varia durante el proceso normal de sanar,
4. usted obtenga un lente similar al solicitar el cambio. Si usted decide mejorar el lente o el diseño, usted será responsable por la diferencia de precio

El paciente, no EOTJ, es responsable por el pago a cualquier óptica fuera de EOTJ por cambios de receta.

Al firmar acá certifico que yo probé la receta de espejuelos, me gustaron y los apruebo.

- ☐ Deseo ordenar mis espejuelos de la óptica de EOTJ.
- ☐ Deseo mi receta para hacerlos en otra óptica.

Firma del Paciente:

Firma del Testigo:

Informed Consent or Refusal for
Dilated Fundus Exam

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply and entry way/opening to the inside of the eye. Looking through an *undilated* pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eye.

A dilated fundus exam is recommended routinely at the time of your initial exam for baseline recording and usually every other full eye exam thereafter (about every 2 to 3 years). It should be done annually if you have any of the conditions listed under **Benefits** below.

Benefits

Dilation allows the doctor a better view of the peripheral retina for disease. It is highly recommended if you or your family has a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment/tears), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, “curtain or veil-like” obstruction of vision, a sudden onset of many “floaters” or flashing lights off to the side of your vision.

Risks

- Some blurring of vision and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.
- Difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read.
- Induced ocular hypertension. Rare cases have been reported in which redness and sharp pain are experienced because of increased eye pressure. If this happens, contact the doctor immediately.

Check one:

____ I understand the above and consent to have the dilation done.

____ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Signature:____

Date: ____