Appointment Check-In Form
Welcome To Experts On Sight

Appointment Time Today:_____ Arrival Time:_____

First Name:_____Last Name:_____

We are now making greater use of e-mail and text messaging to communicate with our patients. To help us provide the most prompt service possible, please enter your most current email and cell phone numbers below:

Email:

□@yahoo.com □@gmail.com □@hotmail.com □Other: @_____

Cell Phone: _____ - _____ - _____

NOTE: All patient information is kept **STRICTLY CONFIDENTIAL**. Your email or cell phone is **NEVER SHARED.**

Would you like to receive information regarding promotions and special events? Yes___No___

PREVIOUS PATIENT INSURANCE INFORMATION

Patient's or Authorized Person's Signature

IT IS YOUR RESPONSIBILTY to read and understand your insurance policy. The insurance company may not cover certain services and procedures, and you may have an annual out-of-pocket deductible that must be paid by you for vision services. It is also your responsibility to provide the correct insurance information. If you fail to do this, you will be responsible for the payment of services provided by Experts on Sight. In addition, any fees rejected by your insurance company will ultimately be your responsibility to pay.

I authorize payment of medical benefits to Experts on Sight for all medical services provided.

I authorize the release of any medical or other information necessary to process this claim.

I acknowledge my medical and/or vision insurance has not changed from my previous date of service at Experts on Sight.

Patient Name _____ **Date** _____
(Please Print)

Authorized Person's Signature _____

OFFICE USE ONLY

Contact Name _____ Approval Code _____

Effective Date of Plan # _____ Co- Payment _____

Associate Initial _____ Extra Payment (CL fitting, dilation, etc) _____

Ins. Payment Received _____ Patient Total _____

HCFA Printed _____ Ins. Payment _____

Welcome back to our office! Please provide us with any changes to the following information.

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY/STATE_____ZIP_____

HOME PHONE _____ WORK/CELL PHONE _____

EMAIL_____

HAVE YOU CHANGED YOUR VISION INSURANCE? Yes No *If yes, please complete a new Insurance Form.*

Medical History *This information is kept strictly confidential*

Please list any Medical Conditions for which you are currently being treated for:

_____

_____

_____

Currently Pregnant or Nursing ❒

Tobacco Use Former ❒
Tobacco Use Current ❒

Please list any Medications you are currently taking (include over-the-counter, vitamins or supplements):
If you have a written list, the receptionist would be more than happy to make a copy.

_____

_____

_____

Please list any allergies you have (include medications, foods, animals, etc):

_____

_____

Pupil Dilation Information

Our office is committed to your eye health as well as ensuring you the best possible vision. We recommend pupil dilation in addition to the routine eye examination.

What are the side effects?
Blurred near vision and light sensitivity for up to 6 hours. Driving is not usually impaired, but may require extra caution.

_____ Yes, I would like pupil dilation in order to ensure the health of my eyes.

_____ No, I understand the importance of pupil dilation, but elect not to be dilated at this time.

Signature _____ Date _____
(If you are under the age of 18, your parent's signature is required)

We are a HIPAA Compliant Office.

Thank You

VISUAL FIELD SCREENING

We are excited to announce that we have incorporated into our practice a new, highly sophisticated, computerized Visual Field Analyzer. Unfortunately, routine eye examinations do not detect many diseases in their early stages. However, the Visual Field Analyzer is like having a "cat scan" specifically for the eye.

The Visual Field Analyzer can detect diseases such as pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to vascular problems and medications.

We strongly recommend that all of our patients over the age of 30 receive this evaluation. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems or have a family member which suffers from glaucoma or retinal problems.

This state of the art procedure requires an addition 10 to 15 minutes of your time and there is a nominal fee of $25.00.

Please check the appropriate box below and sign.

_____ I would like a Comprehensive examination including the Visual Field Screening.

_____ I understand the importance of the Visual Field Screening and understand this test would be in my best interest, but, at this time, I prefer the General Eye Examination only which will not include the Visual Field Screening.

Signature: _____ Date _____

Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out"certain eye diseases. In the latter case, you may be able to submit your bill for the visual field screening to your major medical insurance company for reimbursement. Other more comprehensive procedures may be found to be necessary and billed at a higher rate.

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CONTACT LENS EVALUATION INFORMATION

Contact lenses are medical devices controlled by the FDA and there is an expected "standard of care" required for contact lens wearers. We are dedicated to providing quality care to ensure your optimal comfort, vision, and most importantly, eye health.

It is not possible to determine in advance whether or not you will be a successful contact lens wearer, due to many factors that can influence your success. These factors include, but are not limited to: your expectations, unusual prescription, corneal shape, eyelid anatomy, manual dexterity, allergies, tear quantity, use of certain medications, willingness to return for follow-up care, improper lens care, and inability to follow lens care instructions or wearing schedule. Please discuss any factors you think may be a potential problem with the doctor before the lens fitting process.

There is a contact lens evaluation fee (starting at $90) which covers the initial evaluation to determine the most appropriate lenses and any additional contact lens related visits for up to 60 days. Additional fees will be charged in cases where extra follow-up visits or additional diagnostic lenses are required. In the event of any irritations or infections during the course of the fitting the doctors will manage your eye(s) as a medical condition. The remainder of the contact lens evaluation will resume after the medical issue is resolved. We will provide a full lens care kit and instructions on the caring and wearing of the lenses, including teaching insertion and removal of lenses.

A routine comprehensive eye exam is required in order to complete any contact lens fitting and evaluation. If it has been more than 3 months since your last routine eye exam, you will be required to have a comprehensive eye exam as well as a contact lens evaluation in order to be prescribed contact lenses.

Boxes of contacts can only be returned for an exchange if they are **unopened, unmarked, do not expire within 2 years, and in original condition, within 3 months. Professional fees and lens care products are non-refundable**.

We appreciate your selection of our office to provide your contact lens services. We will do everything possible to affirm your continued trust in our care. If you have any additional concerns or questions, please do not hesitate to ask our doctors' or courteous team members.

_____ _____

Patient's Name Date

_____

Patient Initial/Parent Initial if minor