WELCOME TO OUR OFFICE

Last Name	First Name	Date

Address	City	State	Zip

Home Phone	Business Phone	Cell Phone	E-mail Address

Employer	Occupation	Birth Date	Age	Sex M☐ F☐

Insurance: Type and I.D.	Primary Insured

Form of Payment: Cash Check Credit Card	Date of the last examination

Whom may we thank for referring you?

Reason for your office visit today: (Check all that apply)

- ☐ Lost or broken eyeglasses
- ☐ Want new glasses
- ☐ Want new contact lenses
  - ☐ Soft
  - ☐ Hard
  - ☐ Colored
  - ☐ Disposable
- ☐ Yearly eye exam
- ☐ Problems with current contact lenses
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Problems with night driving
- ☐ Eyes water
- ☐ Eyes Itch
- ☐ Eyes feel dry
- ☐ Pain in eyes
- ☐ Headaches
- ☐ Eyestrain
- ☐ Droopy eyelid
- ☐ Eyes burning
- ☐ Eyes feel tired
- ☐ "Spots" or floaters/flashes
- ☐ Double Vision
- ☐ Sensitive to light
- ☐ Other _____

Personal Medical History: (Check all that apply to YOU)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Thyroid
- ☐ HIV/AIDS
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ "Lazy Eye"
- ☐ Eye Surgery
- ☐ Eye Injuries
- ☐ Retinal Problems
- ☐ Blood Transfusion?
- ☐ Age Related Macular Degeneration
- ☐ Refractive Surgery
- ☐ Other _____

Family Medical History: (Check all that apply to immediate family members)

- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Disorders
- ☐ Age Related Macular Degeneration

Social History:

- ☐ Do you smoke? No Yes 1-5 per day 1 pack/day more
- ☐ Do you drink? No Yes 1 per day 2-3/week more

Current Medications:

_____

_____

List activities in which you participate:

Computers: How many hours per day? _____

Sports: _____

Hobbies: _____

Are you pregnant: Yes No

If yes, months: _____

Allergies to medications: Yes No

If yes, which ones:

_____

_____

_____

Allergies to contact lens solutions: Yes No

If yes, which ones:

_____

_____

_____

"While we will make every effort to verify and confirm your insurance, it is your responsibility to understand the terms and conditions of your insurance. Payment for co-pays and non-insured services are expected at the time of service. Thank you for allowing us to serve your eye care needs"

Patient Signature/Legal Guardian _____

Xavier Eyecare

RETINAL PHOTO EXAM: Dilated view of the retina without the need for eye drop!

In our continued effort to provide the most advanced technology available to our patients, we have added the state-of-the art Maestro retinal screening equipment to our practice.The instrument greatly enhances our ability to access and monitor your eye health with benefits:

- Early detection of sight-threatening conditions and blindness such as glaucoma,macular degeneration and retinal holes or tears.
- Early detection of life-threatening diseases like Cancer and Cardiovascular disease.
- We have a permanent record to compare and track potential disease and can be seen by the patient.
- Fast,easy and comfortable.
- **Does not require dilating the eye with drops, which causes blurry vision and light sensitivity.**

VISUAL FIELD EXAM :

The computerized visual field analyzer can detect early visual field loss, glaucoma, optic nerve disease, dryness, tumors. It is important for patients with a history of high blood pressure, diabetes, headaches, flashes of light or floaters. It is an excellent adjunct to the Maestro Retinal Camera.

FEES: Insurance or vision benefits do not generally cover these testing. In addition to routine exam fees:

RETINAL PHOTO... $39 VISUAL FIELD ... $20.00 BOTH... $49.00

Please check the appropriate line below and sign

☐ **I DO** want the Retinal Photo and Visual Field (Strongly recommended in a comprehensive exam.)

☐ **I DO** want the Retina Photo only. ☐ **I DO NOT** want the Retina Photo exam.

☐ **I DO** want the Visual Field only. ☐ **I DO NOT** want the Visual Field test.

☐ I would like more information.

Patient _____ **Date:** _____

XAVIER EYECARE

DILATION CONSENT FORM

The purpose of dilated exam is to enhance the detection of any ocular pathology, such as cataracts, glaucoma, retinal hemorrhages, retinal detachments, malignant growths,or any other ocular conditions. It is especially important for a patient with a history of diabetes, high blood pressure, headaches, migraines, floaters, high spectacle prescription or family history of eye diseases.
This is a relatively painless procedure.There are some minor side effects associated with dilation. These include sensitivity to light, blurred vision, mild burning on instillation of the drops, inability to focus and do near work.

These side effects usually last approximately 3-5 hours. Some patients may find it difficult to drive after being dilated,and thus bring a driver with them.
I understand the importance and side effects of having my eyes dilated and at this time request to:

☐ **Have my eyes dilated** ☐ **Not have my eyes dilated** ☐ **Take responsibility to reschedule my dilation**

Patient/Legal Guardian Signature:_____ Date :_____

PATIENT RESPONSIBILITY STATEMENT

Thank you for choosing our offices for your eye care needs. As your eye care provider, we are committed to providing the best eye care services possible. Please understand that payment of your bill is considered a part of your care.The following statement explains our Financial Policy, which we ask you to read and sign.

1.) Services are rendered to the patient, not the insurance company. As a courtesy,our office will file your insurance if proper information is received.
2.) All applicable co-pays and non-covered services are due at the time of the service.
3.) Please be aware that some of the services are due at the time of service.
4.) We participate in numerous plans. For some insurance plans, we accept assignment of benefits but in all cases we require the guarantor, the person who is financially responsible,to be personally liable for all balances not covered by insurance. **While we will make every effort to verify and confirm your insurance benefits, it is your responsibility to understand the terms and conditions of your plan.**

I have read and understand the above policy. I hereby accept the above policy and further agree that I shall be responsible for any balance due if insurance does not pay the entire amount.

_____ _____ _____
Print Name Patient Signature/Legal Guardian Date