



Appointment Checklist

In order to make sure your appointment runs as smooth as possible and you get the best possible care we have created a checklist of items you should complete before arriving for your appointment.

Please bring the following:

- Your most current pair of glasses
- Your most current box or package of contact lenses
- A current list of Medications you are taking
- Your completed "New" or "Returning" Patient Registration Forms
- A copy of both your Vision Plan and Medical Insurance Cards
- Any eye drops you are using

Please Remember the following:

- Please arrive 10 minutes prior to your appointment to complete testing prior to seeing the doctor.
- If you are utilizing a Vision Plan or Medical Insurance please make sure you are eligible before you arrive. Please contact your carrier with any questions you may have about your benefits or eligibility prior to your appointment.



complete family
EYECARE

PATIENT REGISTRATION

Date _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Sex: M _____ F _____

Address _____ City _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Social Security#: _____ Home Phone #: _____

Work #: _____ Cell #: _____ Emergency Contact: _____ PH#: _____

E-mail Address: _____ Marital Status: Single __ Married __ Divorced __ Other _____

Employer/School: _____ Occupation/Grade: _____

Employer Address: _____ Employer Phone # _____

Responsible Party: _____ Names of Family Members in Household _____

Private Pay: _____ Primary Insurance: _____ Secondary Insurance: _____

*We must have a copy of all insurance cards on the day of service

Insured's Name: _____ Insured's DOB: _____ Insured's Social Security #: _____

Family Doctor: _____ Preferred Pharmacy: _____

CONSENT TO TREAT: I/We hereby authorize Complete Family Eye care to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co pay or any other balances not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf of Complete Family Eye Care. **Beneficiary Agreement:** I have been notified that Medicare may deny payment for some services. If Medicare denies payment, **I agree to be personally and fully responsible for payment.**

Notice of Privacy Practices: I/We have been offered a copy of Complete Family Eye Care's HIPPA on privacy practices.

Authorization to Release Information: I/We hereby authorize Complete Family Eye Care to release any medical or incidental information that may be necessary for medical benefit in processing applications for financial benefit. This includes but is not limited to my insurance company.

Signature: _____ Date: _____

Patient Questionnaire

If you are a new patient, how did you hear about us? __Newspaper __Phone Book __Friend
__Website __ Radio __ TV Other _____?

Are your eyes sensitive to sunlight? _____

Do you spend time outdoors? _____

How many hours a day do you work at a computer? _____

Do you experience problems with glare or reflections? _____

Do you prefer not to wear glasses at times? _____

Are you interested in the newest in contact lens technology? _____

Do you sometimes experience dry eyes? _____

Would you like information on thinner and lighter lenses? _____

Would you like information on LASIK or other forms of laser vision correction? _____

Did you know there are non-surgical treatments to correct vision? _____

Is there a particular eye disease you have concerns about? _____ What is it? _____



RETINAL IMAGING CONSENT FORM

As part of your eye exam, we at Complete Family Eye Care recommend a special diagnostic procedure called retinal imaging. This procedure consists of capturing an image of the back part (retina) of your eye. This is not an X-ray or ultrasound procedure; and nothing will touch your eye. We are simply taking a digital picture.

This permanent record is very valuable to the doctor in assessing the current health of your eye; and for safeguarding the health of specific structures of your eye such as the retina, optic nerve, macula, and blood vessels. In some cases it may detect diabetic eye changes, macular degeneration, and high blood pressure changes. It will also serve as an initial point from which to compare, as we follow your health in subsequent years.

The fee for this additional part of your eye exam is only \$28.

_____ Yes, I want to have retinal photos taken of my eye for documentation

_____ No, I do not wish to have retinal photos taken.

_____ I would like to consult with the Practitioner before deciding

Printed Name: _____

Patient Signature: _____

Date: _____