GENERAL INFORMATION

First, Last, MI, Preferred Name _____

Street Address _____

City, State, Zip _____

Home Phone _____

Cell Phone _____

Email _____

Preferred Contact Method *cell phone / email / text / other (please explain)* _____

Patient Social Security Number _____-_____-_____

Date of Birth _____/_____/_____

Male/Female _____ Primary Care Doctor Name/Phone #: _____

Occupation/Employer _____ *full-time / part-time*

Marital Status *married / single / divorced / legally separated / widowed*

Language, Race, Ethnicity _____

Emergency Contact Person _____ Phone # _____

INSURANCE INFORMATION

Vision Insurance Carrier _____

Vision Insurance Member Name _____

Vision Insurance Member ID# _____

Vision Insurance Member Date of Birth _____/_____/_____

Primary Medical Insurance Carrier _____

Primary Member Name _____

Insurance ID# _____

Insurance Policy#/Group ID# _____

Primary Member Date of Birth _____/_____/_____

Primary Member Social Security Number _____-_____-_____

Primary Member Employer _____

Your Relationship to Primary Member *spouse / child / other (please explain)* _____

Secondary Medical Insurance Carrier _____

Secondary Medical Insurance Member Name _____

Your Relationship to Primary Member *spouse / child / other (please explain)* _____

Secondary Medical Insurance ID# _____

Secondary Medical Insurance Policy #/Group ID# _____

Secondary Medical Insurance Member Date of Birth _____/_____/_____

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EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit?

Have you or a family member experienced, or been treated for any of the following conditions?

Please circle

Cataracts	Yes	No	Family
Crossed Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LASIK or RK	Yes	No	Family
Lazy Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experienced any of the following?

Circle all that apply

	Distance or Near
o Blurry Vision	
o Burning	o Light Sensitivity
o Discharge	o Redness
o Double Vision	o Sandy or Gritty Feeling
o Dryness	o Light Flashes
o Excess Tearing/Watering	
o Eye Infection	o Headaches
o Eye Pain or Soreness	
o Floaters or Spots	o Itching
o Halos	

MEDICAL HISTORY

Have you or a family member experienced, or Been treated for the following?

AIDS/HIV	Yes	No	Family
Allergies	Yes	No	Family
Arthritis	Yes	No	Family
Asthma	Yes	No	Family
Blood/Lymph Disorder	Yes	No	Family
Cancer	Yes	No	Family
Diabetes	Yes	No	Family
Ears, Nose Throat Conditions	Yes	No	Family
Gastrointestinal Conditions	Yes	No	Family
Heart Disease	Yes	No	Family
High Blood Pressure	Yes	No	Family
High Cholesterol	Yes	No	Family
Kidney Disease	Yes	No	Family
Lupus	Yes	No	Family
Neurological Conditions	Yes	No	Family
Psychiatric Disorder	Yes	No	Family
Seizures	Yes	No	Family
Skin Conditions	Yes	No	Family
Stroke	Yes	No	Family
Thyroid Dysfunction	Yes	No	Family

Current Medications

(Prescription and Over-the-counter and Dosage)

Medication Drug Allergies

Height:_____ Weight_____

Are you pregnant or nursing?

Do you smoke? Have You Ever Smoked?

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MEDICATION RECORD

Medication	Dosage	Frequency	Route	Reason for Use

Allergies to Medications

Medication	Reaction

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CONSENT

I understand and agree that (regardless of my insurance status); I am responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Lange Eye Care and Associates P.A. of any changes in my status or the above information. I also understand that the doctor may need to use diagnostic dilation drops/medical treatments to help evaluate the health of the eye.

I hereby give my full consent.

_____ _____

Patient Signature Date

_____

Patient/Guardian Signature (If Applicable)

RECIEPT OF NOTICE OF PRIVACY PRACTICES - WRITTEN AKNOWLEDGEMENT

I, _____, have reviewed/received a copy of Lange Eye Care and Associates P.A.'s Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian Date

NOTICE OF BUSINESS RELATIONSHIP

The Lange Eye Institute believes that proper nutrition is an important component of maintaining healthy eyesight. Some of the Optometric Physicians at Lange Eye Care & Associates P.A. have a business relationship, including either an ownership interest or an advisory role, with Fortifeye Vitamins, Inc d/b/a Fortifeye Vitamins. Fortifeye Vitamins is the manufacturer of Fortifeye Complete Plus nutritional supplement and other products that we sell in our offices. We sell and recommend these products because we believe that they are the highest quality available. We want to make sure that you are aware of these relationships before you choose to purchase these products. As the patient, you are free to choose the best product to meet your needs. Our staff would be happy to provide you with a copy of the formulation of Fortifeye Complete Plus, if you would like to compare it to other products. By signing this form, you acknowledge that you are aware of the relationship between Lange Eye Care & Associates, P.A., its optometric physicians and these companies.

_____ _____

Patient Signature Date

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OPTICAL WAIVER

The Lange Eye Institute is a material provider for your vision insurance company. The following information is our refund policy regarding eye wear:

Eye wear is a custom-made product designed by your doctor and eye care professionals, especially tailored to each individual patient's needs. It is our policy that there will be NO REFUNDS OR EXCHANGES ON CUSTOM-MADE EYE WEAR.
Please be certain that the eye wear YOU have chosen is what you desire before it is custom made.

We thank you for your patronage.

Patient Signature Date

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Release of Medical Information Consent

This is to authorize Lange Eye Institute that the following individuals have my permission to discuss my personal health information in connection with the diagnosis, treatment, and financial services rendered at Lange Eye Institute.

Individual that may receive information on my behalf:
Name: _____ DOB:_____
Address: _____
City, State, Zip: _____
Phone: _____
Relationship to patient: _____

Individual that may receive information on my behalf:
Name: _____ DOB:_____
Address: _____
City, State, Zip: _____
Phone: _____
Relationship to patient: _____

_____
Patient/Guardian Signature Date

_____
Print Patient Name

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Annidis RHA Imaging Examination Consent Form

Lange Eye Institute is pleased to provide the most highly advanced technology available in retinal screening to our patients. Our ability to view your internal retinal health is dramatically improved with the Annidis RHA.

How does the Annidis RHA Work?

The technician will perform the Annidis RHA for the doctor when you are called back. You will sit in our Annidis RHA room, rest your chin and forehead on the rests, and focus on one green light during the test. Multiple flashes will occur as the machine takes pictures from the front superficial layers of your eye to the back deep retinal layers and save the images seperately. You will repeat the same steps for your other eye as well. Nothing touches your eye during the exam and the test is usually complete within 5-7 minutes.

What does the Annidis RHA provide to my doctor?

This imaging exam is suggested to be done annually for your physician to see an in-depth view of your superficial and deep retinal layers (where ocular disease usually starts). This machine saves the images in a permanent record in your file which provides us to compare these images each year. Dilation may be required after this exam.

How much does the Annidis RHA cost?

Due to changes in technology, and the Annidis RHA being deemed "Not Medically Necessary" or "Exploratory" vision and medical insurances do not cover this examination. Such equipment could cost hundreds of dollars to perform, however, we are pleased to offer this examination while you are in are office for a **discounted $48 copay**.

Please check one of the following options:

☐ *Yes,* I understand the importance of the Annidis RHA and I would like to have the test performed today. I understand I will owe $48 at check out for this examination along with any applicable copays or deductibles from my insurance for other charges today.

☐ *No,* I do not wish to have the RHA Annidis performed today.

_____ _____

Patient Signature Date Signed