

Patient Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_ Parent/Guardian DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_

Race:	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian	<input type="checkbox"/> African American	<input type="checkbox"/> American Indian	<input type="checkbox"/> Other
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Married	Spouse's Name: _____	
Communication Preference:	<input type="checkbox"/> Phone	<input type="checkbox"/> Texting	<input type="checkbox"/> Email	May we text you for appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No		

For new patients, how did you hear about us?

Drive by     Google     Our website     Vision Plan     Referred by: \_\_\_\_\_

**Glasses / Lasik**

Are you interested in new glasses if helpful?                       Yes                       No

Are you interested in information about Lasik?                       Yes                       No

**Contacts**

Contact lenses require an additional examination and follow-up appointments. A **contact lens examination fee** is required which covers the additional time and any follow-up visits to fit the contacts. Our contact lens fittings start at \$60 and depend on the difficulty of the fit. Please refer to front desk for any pricing questions.

Are you interested in wearing contacts?                       Yes                       No

Are you wearing contact lenses today?                       Yes                       No

**Medicare and Other Medical Insurances**

By signing, I understand that Insight Eyecare may bill my medical insurance if my exam is not a routine vision exam. I understand that Insight Eyecare is contracted to follow my insurance's billing rules. That may include charging a copay for each visit and that the entire balance of the visit may get applied towards my deductible (which the patient is responsible for) if my insurance plan deems proper. I understand that any service provided not covered by my medical insurance may be my responsibility.

**HIPAA**

By signing, I agree to and understand that this clinic complies with all requirements of HIPAA, my rights to my records and privacy. I understand that there are full copies of the HIPAA statement available at the front desk and waiting room. **I agree to and understand the policy summaries. I understand that full length copies are available and are posted.**

If you would like to authorize us to share your records with anyone such as family or a guardian, list their names below:

Spouse     Children     Parent(s)    Name(s): \_\_\_\_\_

Signed Patient (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

## Digital Eye Scan

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“I want all of my patients to have our disease scan, including kids. It can find diseases earlier than a photo or my microscope. It allows us to detect disease years before vision is affected, meaning we can prevent vision loss before it starts.” Dr. Tate.

- A lasting record of the health of the eyes today to refer back to at future appointments.
- A digital image of the inside of the eye and a safe scan of the macula and optic nerve.
- Your doctor will review and explain the results with you.

Without the eye disease scan, you may be limiting the ability to determine the health of the eye, unless you are scheduled to see Dr. Tate for a Dilated Medical exam. We use mild dilation on all complete, yearly exams.

This is highly recommended if you have glaucoma or macular degeneration in your family. Unless you have already been diagnosed with an eye disease, insurance does not pay for advanced tests like the disease scan. The additional fee is \$35. This is not paid by any insurance.

Yes, I would like the scan     No, I do not want my eyes scanned

By signing below, I confirm that these records are full and accurate to the best of my knowledge.

Signed Patient (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Prayer Request (optional): \_\_\_\_\_

Verbal prayer in exam

Silent prayer