Insight EYECARE

PATIENT INFORMATION SHEET

Patient Name: _____ DOB: _____

(Please Print)

Additional Patient Information

Occupation: _____ Employed by: _____

Parent/Guardian Name (if applicable): _____ Parent/Guardian DOB: _____

Emergency Contact: _____ Emergency Phone Number: _____

Race:	☐ White	☐ Hispanic	☐ Asian	☐ African American	☐ American Indian	☐ Other
Marital Status:	☐ Single	☐ Divorced	☐ Widowed	☐ Married	Spouse's Name:	
Communication Preference:	☐ Phone	☐ Texting	☐ Email	May we text you for appointment reminders?	☐ Yes ☐ 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

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) ☐ Other: _____

Signed Patient (or Parent/Guardian): _____ Date: _____

Digital Eye Scan

"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 $25. 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

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