Patient's First Name: ______________________
Last Name: ______________________________
Address: ________________________________
City____________________ State_______ Zip__________
Date of Birth: _____________ Last 4 of SSN: _________
Marital Status: S / M / D / W
Home: (_____) _________________
Cell: (_____) _________________
Email:
____

Communication Preference:
☐ Phone ☐ Email ☐ Postal

Financial Responsibility

Please Note: Most Vision Plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems fall under your medical coverage. If you have any questions about your coverage. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

By signing below, you are authorizing Cary Family Eye Care to bill your insurance for services provided and to release all necessary medical information to process the claim. You authorize payment to be made directly to Cary Family Eye Care. **The insurance carrier presented at the time of service will be the only insurance billed. No exceptions can be made.** If your insurance company has not reimbursed our office in full within 90 days, you will be billed for your visit.

Signature: ________________________________
Date: ____________________

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I am familiar with the privacy policy statement of Cary Family Eye Care.

Signature: ________________________________

Established Patient Information

Pupil Dilation

A thorough exam with dilation is often the first step in diagnosing a condition that could possibly have devastating effects on your vision. Drops are used to give your doctor a larger view of the inside of your eye and retina periphery. We look for tumors, retinal detachments, macular degeneration, and other diseases or defects. You may experience light sensitivity and decreased near vision for 2-6 hours. We will supply you with disposable sunglasses for your comfort. This will only be performed if the doctor determines it to be indicated.

Initial: ____________ I accept dilation today
Initial: ____________ I do NOT accept dilation today

Ocular History

Have you recently experienced, been diagnosed with, or treated for any of the following:

☐Blurry Vision ☐Cataracts
☐Floaters/Spots ☐Trouble seeing at night
☐Eye Injury ☐Iritis/Uveitis
☐Headaches ☐Corneal Abrasions
☐Double Vision ☐Crossed eye/Eye turn
☐Flash of light ☐Glaucoma
☐Sunlight Sensitivity ☐Macular Degeneration
☐Retinal Detachment

Any problems with your current glasses/contact?
____

Please list any changes to your medical history since your last visit: ___________________________
____

Please list any changes to your medications since your last visit to our office: ____________________
____

Primary Physician: ___________________________
Physician Telephone: _________________________

Date of last physical exam: ____________________