PEAK EYE CARE

Welcome to our office! We want to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (Please print)

Patient Information

Last Name_____ Suffix_____ First Name _____

Middle Initial _____ Preferred name _____

Gender _____ Marital Status (circle): Married Single Divorced Widowed Other

Mailing Address _____ City _____

State _____ Zip code _____ Home # _____Cell # _____ Text? Y ____ N ____

Social Security # _____ Date of Birth _____ Age _____

Emergency # _____ Emergency Contact _____

Patient Employer _____ Occupation _____ Work #_____

Email Address _____ May we send you information via email? Y ____ N ____

Have you been diagnosed as diabetic? Y ____ N ____ Do you currently wear glasses or contacts? Y ____ N ____

What is the name of your Primary Care Physician? _____

Responsible Party or Primary Insurance Card Holder Information (Parent or Guardian information if under 18)

Responsible Party (If other than self) _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____

Zip code _____Social Security # _____ Phone # _____ Date of Birth _____

Primary Insurance _____ Name of Policy Holder (If other than self) _____

Policy Holder Social Security # _____ Date of Birth _____ Employer _____

Policy Release

I hereby authorize Peak Eye Care (PEC) to release information concerning my medical or other information to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to PEC for my insurance benefits including major medical insurance. I understand that I am financially responsible to PEC for my charges and that the filing of insurance does not relieve me of this obligation. I further authorize any payment made by insurance companies that are incorrect to be refunded to the insurance company. When you provide us with a wireless telephone number or land line you are giving us your prior express consent to call that number. I consent to Optomaps, visual fields, or other photo testing as recommended by my doctor. Policies regarding glasses, contact lenses and contact lens fittings are available at check in, upon request.

Patient/Guardian Signature _____ Date _____

Print name _____ Relationship to patient _____ NP/INS

Optomap (Digital Retinal Photography)

We are very excited about the results of this new technology and highly recommend retinal imaging as an additional test in your eye exam. The fee is only $30, and is generally not covered by health insurance. If a medical diagnosis is found your health insurance will be billed and you will be reimbursed if insurance pays.

Our doctors recommend dilated or Optomap exams for the following patients…

- First-time patients
- Age 50 and above
- With diabetes and hypertension
- With myopia (nearsightedness) of -6.00 or greater
- With family history of glaucoma
- With pre-existing diagnosis of ocular disease that requires regular monitoring
- Who have not been dilated or had Optomap in 2 or more years

Optomap Provides:

- An in-depth view of the retinal layers (where disease can start).
- The ability to show you your images today during your exam.
- A permanent record for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease.

Optomap:

- Is fast, easy, and comfortable.
- Will NOT require dilating drops (which result in blurred vision and sensitivity to light).

____ I elect to have an Optomap of my retina and agree to pay $30 for it today.

____ I decline the Optomap exam. (If you decline the Optomap exam, you agree to dilation if the doctor deems it necessary based on the above criteria.)

Patient Signature: _____ Date_____

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice you may obtain a revised copy on our website at peakeyecare.com.

I hereby acknowledge that I have reviewed or have been made available a copy of Bartlett, Grigsby, Boan & Associates' Notice of Privacy Practices to review.

Patient/Guardian Signature _____ Date _____

Medical Information Release Form (HIPPA Release Form)

I authorize the release of information including the diagnosis, records: examination, rendered to me and claims information. This information may be released to:

____ Spouse _____

____ Child/Children _____

____ Other _____

____ This information is NOT to be released to anyone.

Patient Name _____ Date of Birth _____