

PATIENT'S NAME: _____ Today's Date: _____

SSN: _____ Male Female D.O.B. : _____

Mailing Address: _____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Email Address for Notifications: _____

Phone Number: _____ Alternate Phone Number: _____

GUARANTOR'S NAME: _____ Today's Date: _____

SSN: _____ Male Female D.O.B.: _____

Mailing Address: _____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Phone Number: _____ Alternate Phone Number: _____

PRIMARY MEDICAL INSURANCE: _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured : _____ GRP# _____

SECONDARY MEDICAL INSURANCE: _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured: _____ GRP# _____

VISION Insurance: _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured (Notate if Retired) : _____ GRP# _____

REFERRAL INFORMATION: Name of Doctor: _____ PCP PEDS SPECIALIST

Reason for Referral: _____

Referred by Friend or Family Member: _____

SPECS Eye Care Medical History

Name of Patient _____ Today's Date _____

Please check any problems you have currently or have been diagnosed with in the past:

- | | |
|--|---|
| <input type="checkbox"/> Age-related macular degeneration | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal defects (tears, detachments) |
| <input type="checkbox"/> Diabetes; last A1C: _____; doctor who treats: _____ | <input type="checkbox"/> Eye Surgery: Type _____ |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Amblyopia/Patching |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Injury to Eyes |
| <input type="checkbox"/> Floaters/Flashes of light | <input type="checkbox"/> Nystagmus |

Do you have any other concerns with your eyes or vision? _____

Do you currently wear? Glasses or Contact Lenses: please list the brand (if known) _____
How often do you sleep in your contact lenses? _____ How often do you replace them? _____

Review of Systems (please check any that apply):

Constitutional

- developmental delays/disabilities
- cancer
- fever

Ears/Nose/Throat

- Hearing loss
- Allergies/sinusitis

Neurological

- Multiple Sclerosis
- Seizures
- Cerebral Palsy
- Tumor
- Stroke
- Headaches/Migraines

Psychiatric

- Depression/Anxiety
- Attention deficit disorder

Cardiovascular

- High Blood pressure
- Heart disease

Respiratory

- Asthma
- Emphysema/COPD
- Sleep Apnea

Gastrointestinal

- Crohn's
- Acid reflux

Genitourinary

- Kidney disease
- Prostate
- STD
- Pregnant/Nursing

Musculoskeletal

- Arthritis

- Fibromyalgia

Integumentary

- Rosacea
- Psoriasis
- Cold Sores/Shingles

Endocrine

- Diabetes: Type 1 or Type 2
- Thyroid

Hematologic/Lymphatic

- Anemia
- High cholesterol

Allergy/Immunology

- Drug allergy: _____
- Environmental Allergy
- Rheumatoid arthritis
- Lupus
- Sjogren's Syndrome

Please list any other medical conditions: _____

Please list any current medications (with dosage if known): _____

Social History

Do you smoke or use tobacco? No Yes: How much/often? _____ Do you drink alcohol? No Yes: How much/often? _____

Family History

Does anyone in your immediate family (parents, grandparents, siblings, children) have any of the following medical conditions? (please **check** all that apply and **list who** next to the condition)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Diabetes | |



Casey N. Roland, O.D.
4409 Evans to Locks Road Evans, Georgia 30809

OPTOMAP RETINAL PHOTOS vs. DILATED FUNDUS EXAM

Patient's Name _____

Date _____

At Specs Eye Care, we pride ourselves on providing the best possible patient care. **Because of this, we now perform the Optomap® Retinal Exam with all of our patients.** This non-invasive procedure allows Dr. Roland to see a much broader and more detailed view of the retina compared to undilated examinations. When reviewed, the scan becomes a permanent part of your medical file, enabling Dr. Roland to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Dr. Roland strongly believes that the Optomap® retinal exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.**

***Without either the Optomap or dilation of the pupils, your eye doctor may be unable to detect some health problems such as glaucoma, cataracts, retinal detachments or tears, diabetes, high blood pressure and some tumors. Dr. Roland believes a good look at the retina is the only way to have a complete and thorough eye examination.**

Please INITIAL:

_____ I prefer to have the **Optomap® Retinal Screening Exam** instead of having my eyes dilated. *In very rare instances, the doctor may need to perform a dilated fundus exam in addition to the photos. I understand that there is an **additional fee for the Optomap**. In some cases, we may be able to file your **vision** or **medical insurance** for your photos. A dilated fundus exam is included with the comprehensive eye exam at no additional charge.

NOTE If you choose to have the Optomap photos taken, there is a very small chance your eyes may still have to be dilated if Dr. Roland finds it necessary.

_____ I prefer to have my eyes dilated today. I understand the risks/potential **side effects** of the dilation, including **blurry vision and light sensitivity**. I have a driver with me or will arrange for one at the conclusion of the exam if I feel I am unable to drive safely.

_____ (**Established Patients ONLY**) I prefer to reschedule or defer the dilation. I understand that there may be diseases, conditions, and/or problems that the doctor cannot rule out as a result of not being dilated or having the Optomap® screening. Therefore, I do not hold Dr. Casey N. Roland or the associates of Specs Eye Care liable for any delay in diagnosis and treatment that may result from my deferring the above options today. I understand that is my or my guardian's responsibility to reschedule this portion of my exam.

Patient's/Guardian's Signature: _____ Date: _____



Casey N. Roland, O.D.

4409 Evans to Locks Road, Evans, Georgia 30809

PAYMENT & INSURANCE POLICY, CONSENT & HIPAA

Patient's Name: _____ Date: _____

Current Address: _____

PAYMENT POLICY/ASSIGNMENT OF BENEFITS to FILE INSURANCE/RELEASE OF INFORMATION:

*I hereby authorize payment directly to SPECS Eye Care. All Self-Pay or Insurance Co-Pay, including non-covered services, are due at the time of service. I understand that I am responsible for all charges not covered by my insurance. Self-Pay discount is not allowed for services billed to my insurance carrier. I hereby authorize release of all information necessary to pay my claim. There is a **\$50** insufficient funds fee for all returned checks. There will be additional fees for any past due balances that are transferred to a collection agency.

Insured/Parent/Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

*I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Insured/Parent/Guardian Signature: _____ Date: _____

ROUTINE VISION PLAN vs. MEDICAL INSURANCE

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and Specs Eye Care accepts most vision care plans and insurance plans in both categories: (1) **Routine** Vision plans (such as VSP, VCP, EyeMed & Spectera) and (2) **Medical** insurance (such as Blue Cross/Blue Shield, United Health Care, Medicare and others).

- Vision Plans cover **ONLY** routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Routine Vision plans do **NOT** provide for MEDICAL EYE HEALTH CARE NEEDS.
- Medical Insurance **MUST** be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.
- If you have both Routine Vision Care benefits and Medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.
- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your routine vision plan provider and medical insurance card(s) and identification, for your benefit, to our staff so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

By signing below, I acknowledge that I fully understand the difference between Routine vs. Medical Insurance:

Insured/Parent/Guardian Signature: _____ Date: _____