EyeCare EyeWear

PATIENT INFORMATION

SS#_____/_____/_____ DOB _____-_____-_____ Sex _____ Age _____

Last Name _____ First Name _____ Middle Initial _____

Title ☐ Dr. ☐ Master ☐ Mr. ☐ Miss ☐Ms. ☐ Mrs. Nickname _____ Marital Status ☐ M ☐ D ☐ S ☐W

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Email _____

Employer/School _____ Occupation/Grade _____

Person to contact in case of emergency _____ Phone _____

INSURANCE INFORMATION

Primary Insured _____ Relationship to patient _____

Primary Insured Address _____ City_____ State _____ Zip _____

Employer _____ DOB _____-_____-_____ SS# _____/_____/_____

Insurance Co _____ Insurance ID _____

ASSIGNMENT AND RELEASE OF INSURANCE INFORMATION

I, the undersigned certify that I (or my dependent) have insurance with the above and assign directly to **EyeCare and EyeWear** all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. *Initials*_____

FINANCIAL RESPONSIBILITY

Payment is required at the time of service. Phone orders are subject to the same rules as an in office transaction. Any check returned will be assessed an additional $25.00 fee. Any balance unpaid will be turned over to a collection agency after notification. *Initials*_____

RETURN POLICY

Eyeglasses are a custom made product, made specifically for your prescription and measurements, therefore, refunds will not be given. We will recheck/ remake your lenses one time at no charge within 30 days of purchase date. Additional rechecks/ remakes will be at the patient cost. Contacts must be unused, unworn, and in the state you received them –including unopened, original packaging. Open contact lens boxes, are not eligible for return. No refunds will be offered for services rendered under any circumstance. *Initials*_____

EYEGLASS WARRANTY

Frames* ~ Your frame comes with a warranty against manufacturer defects for 1 year from date of purchase, with the exception of Nike, Flexon & Silhouette which warranty for 2 years. *Frames will be replaced under warranty for a $20.00 shipping fee.*

Lenses* ~ Your lenses will have a 1 year, 1 time scratch warranty on them if you purchased Scratch Protection, Standard Non-Glare and or Polycarbonate Lenses. Your lenses will have a 1 year 2 time scratch warranty on them if you purchased Crizal Brand Non-Glare. *Lenses will be replaced under warranty for a $15.00 shipping fee.*

Progressive Lens Non-Adapt* ~ You have 90 days from the date of purchase to exchange your progressive lenses for conventional single vision, bifocal or trifocal lenses. NOTE: The cost of the progressive lenses will not be refunded as a new pair of lenses will be made at no charge.

**Your insurance companies warranty shall supersede any manufacturer warranty. Initials*_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed/ received a copy of EyeCare and EyeWear's Notice of Privacy Practices. *Initials*_____

I HAVE READ, UNDERSTOOD AND COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature _____ Date _____

EYECARE AND EYEWEAR

Name_____ Date _____

Name of General Physician_____ Name of Last Eye Physician _____

How did you hear about us: Advertisement_____, Patient _____ Doctor_____, Insurance_____, Other _____

If patient selected, who may we thank for referring you? _____

Are you interested in?

Contact Lenses (colored/clear/bifocals) Y/N

Laser surgery to correct your vision Y/N

Please list any current contact lens brand _____

Please list any hobbies/activities _____

Please list any medications _____

Please list any allergies _____

PATIENT EYE HISTORY (Please circle S= Self; N= None)

S/N Blurry Vision	S/N Distorted Vision	S/N Double Vision	S/N Vision Loss	S/N Dry Eyes
S/N Redness	S/N Mucous Discharge	S/N Gritty Feeling	S/N Itching	S/N Burning
S/N Tearing	S/N Light Sensitivity	S/N Eye Pain/Soreness	S/N Tired Eyes	S/N Eye Strain
S/N Flashes of Light	S/N Floating Spots	S/N Twitching Eyelid	S/N Headaches	S/N Eye Injury

PATIENT AND FAMILY EYE/MEDICAL HISTORY (Please Circle S= Self; F= Family; N= None)

S/F/N Glaucoma	S/F/N Eye surgery	S/F/N Macular Degeneration	S/F/N Cataracts	S/F/N Depression
S/F/N Retinal Hole/Tear	S/F/N Lazy Eye	S/F/N Diabetes	S/F/N Hypertension	S/F/N HIV
S/F/N Heart Problems	S/F/N Skin Condition	S/F/N Diarrhea	S/F/N Constipation	S/F/N Colitis
S/F/N Crohn's Disease	S/F/N Kidney Disease	S/F/N Bladder Problems	S/F/N Fever	S/F/N Anemia
S/F/N Seizures	S/F/N Headaches	S/F/N Asthma	S/F/N Bronchitis	S/F/N Thyroid
S/F/N Bleeding Problems	S/F/N Muscle Pain	S/F/N Joint Pain	S/F/N Lupus	S/F/N Chronic Cough
S/F/N Cancer	S/F/N Weight Loss/Gain	S/F/N Sinusitis	S/F/N Allergies	
S/F/N Dry Mouth/Throat	S/F/N Hepatitis	S/F/N Arthritis	S/F/N Fibromyalgia	

SOCIAL HISTORY (Please indicate amount/ type. Indicate NO if it does not apply)

_____Smoke _____ Drink _____ STD _____Street Drugs _____Pregnant/Nursing

Dilation: In order to fully examine your eye health, it is necessary to dilate your pupils. Dilation requires the use of drops that may make your vision blurry and or sensitive to light for 3-7 hours. Dilation is not necessary to get a glasses or contact lens prescription.

Do you authorize the doctor to dilate your eyes today? **Yes _____ No, I will reschedule at no extra charge _____**

I HAVE READ, UNDERSTOOD AND COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature _____ Date _____

(For Office Use Only) Reviewed:

Date_____/Initials_____/Dilation Y/N Date_____/Initials_____/Dilation Y/N Date_____/Initials_____/Dilation Y/N