EDWARDS EYE CARE

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Welcome to our Office!

The mission of Edwards Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. Everything we do shall communicate this. The information and questions below will remain confidential, and are critical to the evaluation of your vision and health. Therefore it is very important that every question be answered in detail. Thank you.

PATIENT INFORMATION **TODAY'S DATE: _____**

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M / F

ADDRESS: _____ LAST 4 of SS#: _____
(Street) (City) (State) (Zip)

WORK: _____
EMAIL: _____ HOME PHONE: _____ CELL: _____

PREFERED CONTACT NUMBER: ( ) Home ( ) Work ( ) Cell ARE WE AUTHORIZED TO TEXT YOU? Y / N

NAME/ADDRESS OF PRIMARY CARE PHYSICIAN: _____ DATE OF LAST EXAM: _____

NAME OF PHARMACY: _____

NAME/ADDRESS OF LAST EYE EXAM: _____ DATE OF LAST EXAM: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

NAME OF SPOUSE/PARENT (Please Circle): _____
WORK: _____
CELL: _____

INSURANCE HOLDER (Please circle): SELF / SPOUSE / PARENT

VISION INSURANCE: _____ MEMBER ID:_____ PRIMARY'S LAST 4 SS#: _____

MEDICAL INSURANCE: _____ MEMBER ID: _____ PRIMARY'S DOB: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU ( ) NONE :

( ) Cataracts
( ) Macular Degeneration
( ) Diabetes
( ) Diabetes Retinopathy
( ) Dry Eyes
( ) Eye Infection, Inflammation, or Allergy
( ) Floaters / Flashes of Light
( ) Retina Defects
( ) Other _____

CHECK ANY EYE CONCERNS THAT APPLY TO YOU ( ) NONE :

( ) Redness
( ) Burning
( ) Itching
( ) Tearing
( ) Discharge
( ) Other _____

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)

( ) Yearly Check Up
( ) Blurred Vision
( ) Eye Strain
( ) Eye Pain
( ) Sensitivity to light
( ) Headaches
( ) Poor Night Vision
( ) Night Glare
( ) Double Vision
( ) Sudden Vision Loss
( ) Eyelids matted shut
( ) Mucous Discharge eyes
( ) One eye turns in or out
( ) Floating spots in vision
( ) Foreign matter in eyes
( ) Red eyes
( ) Seeing flashes of light
( ) Contact lens discomfort
( ) Eye Itching or Allergies
( ) Other _____

EDWARDS EYE CARE

CURRENT MEDICATIONS: ( ) NONE ( ) YES: _____
Including prescription, over the counter, natural herbs, vitamins, and birth control. Use space below if needed.

ALLERGIES TO MEDICATIONS? ( ) NONE ( ) YES: Please List: _____

DO YOU USE: *DRINK ALCOHOL? ( ) YES ( ) NO ( ) QUIT *TOBACCO PRODUCTS? ( ) YES ( ) NO *USE DRUGS? ( ) YES ( ) NO

IF YES, TYPE/AMOUNT/HOW LONG: _____

CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU ( ) NONE: ( ) OTHER_____

( ) Diabetes- Type 1/Type 2	( ) Vascular Disease/Stroke	( ) Cancer	( ) Skin Eczema/Rash
( ) High Blood Pressure	( ) Seizures	( ) Thyroid Disease- Hypo/Hyper	( ) Kidney/Bladder
( ) High Cholesterol	( ) Lung Disease/Asthma	( ) Arthritis	( ) Psychiatric
( ) Heart Disease	( ) Headaches/Migraines	( ) Weight Loss/Gain	( ) Autoimmune

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS AND INDICATE WHO ( ) NONE: ( ) OTHER_____

( ) Glaucoma _____	( ) Retinal Detachment _____	( ) Blindness _____	( ) Cancer _____
( ) Cataracts _____	( ) Turned/Crossed Eyes _____	( ) Diabetes- Type 1/Type 2 _____	( ) Heart Disease _____
( ) Macular Degeneration _____	( ) Lazy Eye _____	( ) High Blood Pressure _____	( ) Thyroid Disease- Hypo/Hyper _____

CONTACT LENS HISTORY
( ) I do not wear contact lenses
( ) I am interested in wearing contact lenses or would like to know more about them
( ) I currently wear contact lenses; If so, what type: _____ Solution: _____ Sleep in your lenses? YES NO
( ) I am not satisfied with the vision and comfort of my contact lenses

How often do you replace your contacts? (Circle) DAILY 2-WEEKS MONTHLY QUARTERLY YEARLY

OFFICE POLICIES AND WARRANTY INFORMATION

EYEGLASSES
- **One year warranty on manufacturer defect at 100% off. One time replacement only. Other damages are subject to manufacturer approval and may not be covered for full replacement.**
- **If you are not completely satisfied with your frame, we may be able to restyle you in a more suitable frame for a restyle fee of $50 within 30 days. Frames must be in resale condition and show no sign of wear. There is no warranty on lost or stolen frames.**
- **Within 90 days of exam we are able to remake lenses for the following reasons: Doctor's prescription change, Non- adapt of progressive lenses.**

CONTACT LENSES
- **Contact lens products may be exchanged within 90 days of purchase and are subject to a restocking fee of $5 per box. In order to exchange contacts, the boxes must be unopened with no markings or other package alterations on them.**

PAYMENT DUE AT TIME OF SERVICE
- **Payment due at the time services are rendered**
- **Any services not covered by your insurance company will be the responsibility of the patient**

Receipt of Notice of Privacy Policies and Office Policies and Warranty Information
I acknowledge that I have received the Notice of Privacy Practices and the Office Policies and Warranty Information from Edwards Eye Care. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company. I also understand that the premises are under video surveillance, and that these recordings will be kept strictly confidential. Edwards Eye Care may use them in any way deemed necessary, including use by law enforcement and in a court of law.

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Edwards Eye Care. During your evaluation, if the doctor finds a medical diagnosis, this may change the application of your insurance from vision to medical and you will be responsible for any required copays or deductible. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. Please sign below acknowledging that you understand:

Name: _____

If under 18, Name of Parent/Guardian: _____

Signature: _____ Date: _____

I give authorization for Edwards Eye Care to release information regarding my account, if necessary, with:

Name: _____ Relationship: _____ Phone Number: _____