EDWARDS EYE CARE

Dr. Kyle Edwards, OD
7824 Hickory Flat Hwy, Suite 100
Woodstock, GA 30188
(770) 479-0222

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)

EMAIL: _____ HOME PHONE: _____

WORK: _____ 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: _____ PHONE: _____

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

EMPLOYER/SCHOOL: _____

OCCUPATION: _____

WORK: _____

NAME OF SPOUSE/PARENT (Please Circle): _____

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:
_____

EDWARDS EYE CARE

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU **( ) NONE:** **( ) LASIK/RK**

( ) Cataracts
( ) Macular Degeneration
( ) Diabetes
( ) Diabetic Retinopathy
( ) Dry Eyes
( ) Eye Infection, Inflammation,
( ) 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 _____

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

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

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

EDWARDS EYE CARE

What Insurance will be used for my visit?

Our office often has patients that have both medical and vision insurance. They are very different in terms of the services they cover and it's important for our patients to understand these differences. It's important to note that insurance carriers set these rules and our office is obligated to follow them.

Vision coverage is mainly designed to cover a routine evaluation of the eye (in a healthy patient that has no particular problem or symptom), a prescription for glasses, and to help pay for glasses or contact lenses. It is not equipped to deal with and does not usually cover medical conditions and/or treatment plans. Similarly, medical insurance is designed for when you have a medical problem that affects the eyes; it does not cover routine services or examinations for glasses, including routine vision problems such as nearsightedness, farsightedness, and astigmatism.

When a medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, just to name a few, or you have an eye disease/problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again just to name a few, we must often file the claim with your medical insurance; co-pays and deductibles for that particular medical insurance plan will apply. Your vision plan does not cover the kinds of problems discussed in the paragraph above.

In most cases, there is no way to know prior to your examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Edwards Eye Care to file my insurance by the above guidelines.

Signature_____ Date:_____

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: _____