FRANKLIN FAMILY EYE CARE

Welcome to Franklin Family Eye Care. Please take a few moments to fill out this form as completely as you can. If you have questions, we will be glad to help you. Thank you also for providing your insurance cards for our office to scan for our records.

First Name: _____ **Middle**: _____ **Last**: _____

Nickname: _____ **Date of Birth**: _____ **SS#**: _____ **Sex**: __M __F

Address: _____

City: _____ **State**: _____ **Zip**: _____

Marital Status: __S __M __W __D **Preferred Language**: __English __Spanish **Ethnicity**: __Hispanic __Non-Hispanic

Race: __American Indian or Alaskan Native __Asian __Native Hawaiian or Pacific Islander

__Black or African American __White or Caucasian

Employer: _____ **Occupation**: _____

Referred by: _____

We must communicate with our patients regarding appointment reminders, glasses and contact lens notifications, and other pertinent information by text, email, and phone calls. We make every effort to only communicate necessary information. You may opt out at any time. Please list below the contact information you would like us to use.

Preferred Method of Contact: __Text __Email __Phone **Would you like text appointment reminders**? __Y __N

Cell Phone: _____ **Email**: _____

Other: _____

"Our Focus is You" - your health, your time, and your convenience. With your permission, we may disclose your health information and/or products to person(s) you identify below. We will not discuss your protected health information or release products to an individual who is not listed below. This does not apply to information sent to any entity for payment or treatment. This authorization may be changed at any time by submitting a request to our office.

Emergency Contact Name: _____

Phone: _____ **Relationship**: _____

I authorize Franklin Family Eye Care to release **health information** about my eye care to the following individuals:

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

I authorize Franklin Family Eye Care to release **products** (written prescriptions, receipts, glasses, contact lens) to the following individuals:

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

Notice of Privacy Practices: My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Franklin Family Eye Care and have read and understood its content.

Signature of Patient or Authorized Representative: _____ Date: _____

FRANKLIN FAMILY EYE CARE

This form authorizes Franklin Family Eye Care to file your visit with your insurance company. Signing below states that you are responsible for payment once your insurance has paid. If you do not have insurance, signing below states that you are responsible for the balance on your account.

Patient Name: _____ **Date of Birth**: _____

INSURANCE INFORMATION

Vision Insurance Company: _____ ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Primary Medical Insurance Company: _____ ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Medical Insurance Company: _____ ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

RESPONSIBLE PARTY

needed for patients who have insurance under another family member or are not personally responsible for payment

Full Name: _____ **Date of Birth**: _____

Relation to Patient: _____ **SS#**: _____ **Sex**: __M __F

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____

INSURED PATIENT POLICY: Patients must bring all insurance plans to our attention for verification before receiving services/ products. Franklin Family Eye Care must have a copy of the most current insurance information or card. **It is the patient's responsibility to know their plan. The insurance policy is a contract between the patient and his/her insurance company.** If you have given us all the required information and we are a participating provider, we will submit charges to your insurance company. Please be aware that some services provided may be considered as **"non covered"** according to your policy or eligibility. If a service is non covered, *you are responsible for payment*. As a service to you, we will contact your insurance company to estimate their payment. It is essential to know that any information given over the phone cannot be guaranteed and is only an estimate. On the day of your exam, **we require that you pay the estimated difference between the insurance estimate and the provider charges**. Once your insurance has paid, if there is a credit or balance on your account, our office will mail you a refund check or statement.

INSURANCE SIGNATURE ON FILE: I certify that the information given by me in order to file my visit with my insurance company or Medicare is true and correct. **I authorize my doctor to act as my agent to obtain payment of my insurance or Medicare benefits. I authorize any holder of medical information needed to determine these benefits and to process any claim to release it. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Franklin Family Eye Care or Dr. Jon Franklin for services and materials they furnish to me. I understand that Medicare does not pay routine services or materials.** Materials such as eyeglasses or contact lenses may be considered a one time benefit after cataract surgery; otherwise, I am responsible for all material charges. ***Medicare does not cover service CPT 92015** (part of the vision analysis and evaluation which determines your need for eyeglasses). I will be responsible for paying this fee. A photocopy of this assignment is as valid as the original.

AUTHORIZATION: I hereby give my consent to the doctors, staff, and associates of Frankly Family Eye Care to provide eye care services to myself and my family. **I understand and agree (regardless of my insurance status) that I am ultimately responsible for the account balance.** I understand that the staff of Franklin Family Eye Care will make efforts to determine all amounts due at the time of service. However, the insurance company may send an explanation of benefits which may result in a balance due from me. My signature below indicates that I understand and agree with these policies. This assignment will remain in effect until revoked by me in writing. A copy of this policy will be provided to me at my request.

Signature of Patient or Authorized Representative: _____ Date: _____

FRANKLIN FAMILY EYE CARE

Thank you for keeping us completely up-to-date on your medical history. Your vision can be affected by many aspects of your health. If you are a new patient, fill this form out completely. If you are an existing patient, take care to report any new information since your last visit.

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Last Eye Exam (if not here):** _____

EYE HEALTH HISTORY (please check all that apply)

What problems are you CURRENTLY experiencing?

__ Blurry Vision _Far _Close
__ Halos/Glare
__ Redness
__ Flashes/Floating Spots
__ Peripheral Vision Loss
__ Contact Lens Problems
__ Itching/Watering
__ Double Vision
__ Discharge
__ Headaches
__ Pain/Soreness
__ Burning

Other: _____

Do you have any of these ocular conditions?

__ Cataract
__ Glaucoma
__ Macular Degeneration
__ Retinal Detachment
__ Blindness
__ Corneal Dystophy
__ Dry Eye
__ Lazy Eye
__ Crossed Eyes
__ Retinitis Pigmentosa
__ Melanoma of the Eye
__ Nevus (freckle in eye)

Other: _____

Symptoms in __Right Eye __Left Eye or __Both Eyes

Do you wear Glasses? __ Yes __ No

Do you wear Contacts? __ Yes __ No If No, have you worn Contact Lenses in the past? __ Yes __ No

Please List and Explain any Eye Injuries, Surgeries, or Infections: _____

_____

MEDICAL HEALTH HISTORY (please check all that apply)

CARDIOVASCULAR
_Heart Disease
_Stroke
_Hypertension

ENDOCRINE
_Pre-Diabetic
_Diabetes Type 1
_Diabetes Type 2
_High Cholesterol
_Thyroid Disease

PSYCHIATRIC
_Depression
_Anxiety
_Bipolar Disorder

NEUROLOGICAL
_Cerebral Palsy
_Multiple Sclerosis
_Migraines
_Fibromyalgia

MUSCULOSKELETAL
_Parkinson's
_Osteoporosis
_Arthritis
_Osteoarthritis
_Rheumatoid
_Myasthenia Gravis

OTHER
_Crohn's Disease
_Rosacea
_Sjogren's
_Colitis/Sarcoidosis
_Weight Loss/Gain
_Asthma

History of Cancer: __ Yes __ No Type/Year: _____

Other: _____

Are you pregnant? __ Yes __ No

Please List Past Surgeries: _____

_____

Diabetic Patient: Last A1C _____
Recent Blood Sugar Reading _____
Range of Blood Sugar _____
Year of Diagnosis _____

Medications (prescription, over the counter, and vitamins): _____

_____

Allergies to Medication: _____

Pharmacy and Location: _____

Family Medical/Ocular History (indicate MOTHER, FATHER, PATERNAL OR MATERNAL GRANDPARENT)

Glaucoma _____ Cataract _____ Diabetes _____ Stroke _____

Retinal/Macular Disease _____ Retinal Detachment _____ Cancer _____

Social History: Sexually Transmitted Disease? ___Yes ___No Blood Transfusions? ___Yes ___No
Nicotine Products Used? ___Yes ___No Alcohol Use? ___Yes ___Socially ___No
History or Current Use of: ___ Narcotic Pain Meds ___Marijuana ___Heroin ___Other

FRANKLIN FAMILY EYE CARE

Yearly Full Eye Exams Only
Retinal Informed Consent Agreement

Patient Name: _____ **Date of Birth:** _____

A complete examination of the eye cannot be accomplished without an examination of the fundus (the inside part of your eye). Viewing the retina is important to accurately assess eye health and screen for potentially vision-threatening conditions.

You have 2 options to allow us to examine the health of your retina. Please choose an option below.

Option 1: DILATION

There is no charge for dilation and it is included free of charge with your yearly comprehensive eye exam. To dilate the eyes, the technician or doctor will put dilating drops into the eyes and wait for dilation to take place, usually 10-20 minutes. The main side effects of the drops include blurry vision, light sensitivity, and the inability to focus on your near vision for about 3-4 hours. As with all medications, rare but more serious side effects can also occur. It is possible to drive yourself after dilation but we recommend that you have a driver present for dilation. It is possible to reschedule the dilation (within 30 days) if today is not convenient. ***If you have had an allergic reaction to any anesthetics or eye drops, please let us know so we can discuss the best option for you.***

Option 2: OPTOS Optomap (recommended by our doctors)

The OPTOS digital retinal imaging system allows a 200 degree view of the retina. In a matter of minutes, a high resolution photo of your retina will be generated. No drops or medication will be needed to perform this procedure. This is the method recommended by all our doctors. There is a brief, very bright light when the image is captured.

The benefits of examination with OPTOS are:

1. This is a non-drug method of examining the eye so there are no drug side effects. Vision will not be affected as it would be with dilating drops.
2. OPTOS captures an image of a wider view of the retina at one time not obtainable with dilation.
3. Photos are stored in your medical record so they can be compared from year to year to assess for slight changes, which could be the beginning or progression of eye diseases.
4. Shorter visit time.

The charge for the OPTOS Optomap is $39 and, in most cases, is NOT covered by insurance. We will verify at your appointment whether your vision plan covers this service or not. The Optomap is included in our Self Pay Full Vision Exam at no additional charge.

Please select Dilation or OPTOS Optomap below (please select one option).

Option 1: I want to have my eyes dilated at no charge. _____ (initial)

Option 2: I want OPTOS imaging performed for an additional $39 charge. _____ (initial)

Signature of Patient or Authorized Representative: _____ Date: _____