FRANKLIN FAMILY EYE CARE

We are pleased to welcome you 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. **Please present your insurance cards.**

Patient Information

First Name: _____ Middle: _____ Last: _____

Nick Name: _____ Birth Date: _____ SS#: _____ Sex: **O** M **O** F

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Day: _____ Cell: _____ **Text Reminders: O** Y **O** N

Email: _____ **Preferred method of contact? O** Text **O** Email **O** Phone

Marital Status: O S **O** M **O** W **O** D **Preferred Language:** _____ **Ethnicity: O** Hispanic **O** Non-Hispanic

Race: O American Indian or Alaskan Native **O** Asian **O** Native Hawaiian or Pacific Islander

O Black or African American **O** White or Caucasian

Employer: _____ Occupation: _____

Referred by: _____ Emergency Contact Person: _____

Relationship: _____ Emergency Contact Phone: _____

Insurance Information

Vision Insurance

Vision Plan Name: _____ Policy Holder Name: _____ DOB: _____

ID#:_____ SS#: _____ Relation to Patient: _____

Medical Insurance

Primary Insurance: _____ Policy Holder Name: _____ DOB: _____

ID#:_____ SS#: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy Holder Name: _____ DOB: _____

ID#:_____ SS#: _____ Relation to Patient: _____

Responsible Party Information

Fill out if different than the patient information above.

Full Name: _____ Birth Date: _____

SS#: _____ Sex: **O** M **O** F Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Day: _____ Cell: _____

Signature: _____ **Date:** _____

Patient, Guardian, or Authorized Representative

Patient Health History

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Last Eye Exam: _____

Eye Health History: (Please check all that apply)

What problems are you currently having?

O Blurred Vision
O Halos/Glare
O Redness
O Flashes/Floating Spots
O Burning
O Peripheral Vision Loss
O Itching/Watering
O Double Vision
O Discharge
O Headaches
O Pain/Soreness
O Contact Lens Problems

O Other: _____

Do you have any of these ocular conditions?

O Cataract
O Glaucoma
O Macular Degeneration
O Retinal Detachment
O Blindness
O Corneal Dystrophy
O Dry Eye
O Lazy Eye
O Crossed Eyes
O Retinitis Pigmentosa
O Melanoma of the Eye

O Other: _____

Do you wear glasses? O Y **O** N
Do you wear contact lenses? O Y **O** N **If no, have you worn contact lenses in the past? O** Y **O** N

Please list and explain any eye injuries, surgeries, or infections: _____

_____

Medical Health History: (Please check all that apply)

CARDIOVASCULAR
O Heart Disease
O Stroke
O Hypertension

ENDOCRINE
O Diabetes Type 1
O Diabetes Type 2
O High Cholesterol
O Thyroid Disease

PSYCHIATRIC
O Depression
O Anxiety
O Bipolar Disorder

NEUROLOGICAL
O Cerebral Palsy
O Multiple Sclerosis
O Migraines
O Fibromyalgia

MUSCULOSKELETAL
O Parkinson's
O Arthritis
O Osteoporosis
O Myasthenia Gravis

OTHER
O Crohn's Disease
O Rosacea
O Colitis/Sarcoidosis
O Sjogren's
O Weight loss/gain
O Asthma

Other: _____

Are you pregnant? **O** Y **O** N

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

Range of Blood Sugar: _____

Please list past surgeries: _____

Medications (Systemic and Ocular): (Please list all or provide a written list to the front desk/technician)

_____

_____

Allergies to Medications: _____

Pharmacy and Location: _____

Family Medical/Ocular History: (Please indicate MOTHER, FATHER, PATERNAL or MATERNAL GRANDPARENT)

O Glaucoma _____ **O** Cataract_____ **O** Retinal/Macular Disease _____ **O** Retinal Detachment _____

O Diabetes _____ **O** Stroke _____ **O** Cancer _____

Social History: Sexually Transmitted Disease? **O** Y **O** N
Nicotine Products Use? **O** Y **O** N
Narcotic Use? (Pain Med, Marijuana/Heroin) **O** Y **O** N
Blood Transfusions? **O** Y **O** N
Alcohol Use? **O** Y **O** N

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Retinal Exam
Informed Consent Agreement

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). To accurately assess eye health and screen for potentially vision-threatening conditions, viewing the retina is important.

You have two options to allow us to examine the health of your retina: Dilation and OPTOS OptoMap.

Option 1:

DILATION: There is no charge for dilation which 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, which will usually take 10-20 minutes. The main side effects of the drops include blurry vision, light sensitivity, and 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. We recommend that you have a driver present for dilation, and it is possible to reschedule the dilation (within 30 days) if today is not convenient.

I **DO** want to have my eyes dilated. _____ (initial)

Option 2: Recommended by our doctors.

OPTOS OptoMap: 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 not obtainable with dilation all at once.
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 this service is $39 and is NOT covered by insurance.

I **DO** want OPTOS imaging preformed (for a charge of $39). _____ (initial)

Signature: _____ **Date:** _____

Patient or Guarantor

FRANKLIN FAMILY EYE CARE

Care and Communication Preferences and Authorization

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

"Our Focus is You!" - your health, your time, and your convenience. To meet this goal, we offer our patients different ways to participate in their eye care while still protecting their privacy. With your permission, we may disclose your **health information** and/or **products** to a family member or other person you identify. **We will not discuss any information regarding you or your protected health information or release any 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 by you at any time by submitting a written request to our office.

I authorize *Franklin Eye Care, PLLC* to release **health information** about my eye care to the following individuals. (N/A if no-one):

Name	**Relationship**
_____	_____
_____	_____

I authorize *Franklin Eye Care, PLLC* to release **products- written prescriptions, receipts, glasses,** and/or **samples** to the following individuals. (N/A if no-one):

Name	**Relationship**
_____	_____
_____	_____

Communication:

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 communicate only necessary or helpful information. You may opt out of any method in writing or by opting out of the message sent at any time.

Please list the cell number and email address you would like for us to use.

Cell (Text)**:** _____ **Email:** _____

Your signature below indicates you have read, understood the above. It is your responsibility to notify *Franklin Eye Care, PLLC* of any changes.

Patient or Guarantor Signature: _____

Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: _____

Date: _____

FRANKLIN FAMILY EYE CARE

Financial & Insurance Authorizations
Financial/Medical Release

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

INSURED PATIENT POLICY: Patients must bring all insurance plans to our attention for verification before receiving services/products. *Franklin Eye Care, PLLC* 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 Eye Care, PLLC*, or Dr. Jon Franklin for services and materials they furnish to me. I understand that Medicare does not pay for 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 *Franklin Eye Care, PLLC*, 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's balance**. I understand that the staff of *Franklin Eye Care, PLLC*, 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: _____ **Date:** _____

Patient or Guarantor