Returning Patient Check-In Form

Today's Date: ___/___/___

Name: _____ DOB: ____/____/____

Name and address of pharmacy: _____

What is your reason for today's visit?

A. Routine Eye Exam □ For glasses only □ For contacts and glasses

B. Medical Exam □ Red Eye □ Injury/Abrasion □ Follow-up □ Other

Medical History Update

Name of Medical Doctor: _____ Date of Last Medical Exam: _____/_____/_____

Most recent weight? _____ Most recent height? _____

Changes in medications Yes No

*If yes, please explain:*_____

Changes in medical history : Yes No

*If yes, please explain:*_____

Please check any of the following that you are experiencing:

	Yes	No		Yes	No		Yes	No
Blurred Vision- distance	□	□	Itching	□	□	Eye Pain	□	□
Blurred Vision- near	□	□	Burning	□	□	Red Eye	□	□
Loss of Vision	□	□	Dryness	□	□	Watery Eyes	□	□
Double Vision	□	□	Light Sensitivity	□	□	Discharge	□	□
Poor Night Vision	□	□	Flashes /Floaters	□	□	Sandy/Gritty Feeling	□	□
Headaches	□	□	Halos	□	□			

(turn over)

Have there been any changes since your last visit?

□ Name, Address, Phone Number Yes No

□ Insurance Information Yes No

*If yes, please explain:*_____

_____

Your Doctor may suggest performing services that may not be covered by your insurance. Dilation is indicated for new patients, diabetics, highly near-sighted individuals or people having a history of eye health problems. A Visual Field or Retinal Photograph may be required based on the clinical findings of your exam. Additional fees if your insurance does not cover these services are as follows:

Dilation $35	Optical Coherence Tomography	$35	Opto Map Scan $35	Standard Contact Lens Fit $50
Visual Field $35	Digital Retinal Photograph	$20	Refraction (**Medicare patients only**) $50	

Please be aware payment will be due as services are rendered. If you do not want to have these services performed, please let your doctor know at the beginning of your exam. By signing below, you confirm that you are aware of the fees listed above and that the medical information provided on this form is complete, true and accurate to the best of your knowledge.

Patient's Signature: _____ Date: _____/_____/_____