20/20 EYECARE
PATIENT INFORMATION FORM

How did you hear about us: _____

Patient Name: _____
Last First M.I.

Type of Insurance: _____ Are you the Policy Holder: ☐Y ☐N

Member ID #_____ Group # _____

Date of Birth: _____ SSN # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home # _____ Cell # _____ WK # _____

Marital Status: _____ Employment Status: ☐F/T ☐P/T ☐Self ☐Student ☐Retired

Employer: _____ Email Address: _____

ASSIGNMENT RELEASE: I hereby authorize the physician and/or staff to release any information required to process this claim. I also authorize all insurance benefits to be paid directly to the physician, and I understand that I am 100% responsible for any co-pays and/or non-covered services.

_____ _____
Signature Date

Name of Policy Holder: _____
(If different than patient) Last First M.I.

Address of Policy Holder: _____
(If different than above)

_____

Home # _____ Cell # _____ WK # _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

AR: OD _____ PREV. RX: OD _____ ADD _____

OS _____ OS _____

K: OD _____ NCT: OD _____ DFE CONSENT: ☐Y ☐N

OS _____ OS _____ GLASSES: ☐Y ☐N

20/20 EYECARE
Dr. Smitesh J. Patel and Associates
2501 Whittlesey Blvd. Suite A
Columbus, GA 31909
(706) 507-3937

For After Hours Emergencies, I understand that this office is closed and unavailable. I have been informed to call 911, go to the nearest Hospital, or contact an Ophthalmologist on call.

I have also had a chance to review 20/20 EYECARE's, HIPAA Policies.

VIRTUALLY ALL OF THE MAJOR CAUSES OF BLINDNESS CAN BE DETECTED BY CHANGES IN THE VISUAL FIELD

A Visual Field Analyzer checks for loss of sight in both the central (straight-ahead) and peripheral (side-view) areas. Visual Field testing can assist us in the early detection of glaucoma, retinal problems, some neurological diseases (such as brain tumors and optic nerve disease), and enables us to better diagnose causes of headaches.

Most visual field defects are not noticed by an individual until the very late stages. We are committed to the early detection and prevention of eye diseases, which significantly increases the chances of curing the disorder or at least minimizing its effects.

We ***strongly recommend*** that all of our patients receive this test as part of their comprehensive visual analysis. This test is not included in a routine eye examination. The FEE for this test is an additional **$10.00**. Please check the appropriate box below stating your preference and sign below. If you have any questions, please let us know.

☐I DO WANT THE VISUAL FIELD SCREENING ☐I DO NOT WANT THE VISUAL FIELD SCREENING

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Contact Lens Agreement (Only if getting a Contact Lens Fitting Today)

Have you ever worn contact lenses before? ☐ Yes ☐No

Are you interested in colored contacts? ☐ Yes ☐No

Do you have a pair of back-up glasses? ☐ Yes ☐No

If you sleep in your contacts, how many nights in a row do you sleep in them? _____

What type of solution(s) do you use? ☐Biotrue ☐ReNu ☐Optifree ☐Complete ☐AOSept ☐Boston ☐Other

I understand that contact lenses are medical devices and state law prohibits dispensing contacts after one year from the date of the exam. Disposable diagnostic lenses are for fitting purposes only and will be dispensed at the initial fitting exam only. I am aware that a pair of glasses as a back- up for contacts is highly recommended. I also understand that contacts alone do not provide adequate protection from the ultraviolet rays of the sun and that UV-blocking sunglasses should be worn over the contacts for outdoor activities. I also understand that proper protective eyewear is recommended for any sporting activities or any other activities which may pose a risk for eye injuries. I have also been informed and am aware of the risks and dangers of wearing Contact Lenses, including, but not limited to, potential infections, ulcers, pain and redness, corneal scarring, temporary or permanent loss of vision. I understand that if I have any of the above signs/symptoms, I will remove the contacts immediately, put my glasses on, and seek treatment right away. Contact lens exam fees, as with all other professional fees, are non-refundable. Contact lens exams include follow-up visits for 60 days after the initial exam for fit and Rx modifications only. It is the patient's responsibility to make sure that the follow-up is completed within the 60 day time period. If you fail to keep follOw-up visits during the 60 day period, additional office visit charges may apply.

Signed: _____ Date: _____