[REGISTRATION FORM-ESTABLISHED PATIENT] Date_______________

Name____Date of birth________________
First Middle Last

Mobile #________________________________Email address: ____

Reason for Visit: ☐Eye Exam ☐Contacts Lens ☐Medical/Diabetes Exam ☐Emergency

☐Refractive surgery (Lasik/PRK) Consult ☐Other____________________________

*Contact Lens Exams are Not a covered benefit by most insurance. Therefore, will be the patient's responsibility. If you were to have coverage, and if the insurance company does not pay in full, you will be responsible for the differences not covered by your insurance. Additional fees will be applied for New contact lens wearer for the Insertion & Removal teach.

EYE CONDITIONS: Please check any or all that applies.

☐ Blurry Vision ☐ Dry Eyes ☐ Itchy Eyes ☐ Irritated ☐ Redness ☐ Infection ☐ Discharge

☐ Floaters/Flashes ☐ Glaucoma ☐ Pain ☐ Headache ☐ Retinal Disorders ☐ Other: ___________

☐Eye Surgery/Injury____Date______________________

EYE HISTORY: Please check any or all that applies. **S** (yourself). **F** (immediate family)

☐S ☐F Glaucoma ☐S ☐F Macular Degenerations ☐S ☐F Retinal Disorders ☐S ☐F Other______________

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Please indicate if there are any **changes** to the following information:

Phone number/Name ☐No changes ☐Changes____

Address ☐No changes ☐Changes____

Insurance info (Carrier, ID #) ☐No changes ☐Changes____

Eye Conditions (Ex: Surgery) ☐No changes ☐Changes____

Medical Conditions (Ex:Diabetes)☐No changes ☐Changes____

Medications:____

Birth Control: ☐No ☐Yes: Name____________________ Pregnant: ☐No ☐Yes: How far long?______________

Do you use: Tobacco: ☐N ☐Y Alcohol: ☐N ☐Y Recreational Drugs: ☐N ☐Y

Drug Allergies: ☐None ☐Yes: Medication name____

Retinal photos screening: newest state of the art technology allows your eye doctor to screen for many eye conditions such as glaucoma, diabetes, macular degeneration, etc. This is done by taking a picture of the back part your eyes (aka fundus or retinal photos), assuming your pupils are of adequate size. Fees: $30.

Dilation: These are drops that will be instilled in your eyes to dilate your pupils. Dilation will enable your doctor to examine the posterior segment (back part of the eye, such as the retina, optic nerve head, ocular lens, etc.) to better detect for eye diseases such as Diabetic Retinopathy, Cataracts, Glaucoma, Floaters, etc. Recommended for all patients, **especially** those with

medical systemic conditions including Diabetes, High Blood Pressure, etc. Additional charges may apply for a MEDICAL EXAM in addition to a GLASSES EXAM (fees will vary depending on the medical complexity of the case). I understand that if dilation exam is not performed, the Doctor may not be able to detect eye diseases that may be present on the back part of the eye. Common temporary effects of dilation are blurriness at near vision (about 2-4 hours) and increased sensitivity with sun/bright lights (4-6 hours).

Visual field screening: This is a 5 minute computerized analyzer test that enables the doctor to screen for central and peripheral visual defects (what you are able/unable to see in the front and on the side of your vision). This tool is used to rule out brain tumors, glaucoma, retinal tears/holes, etc. Fee: $15.00.

Value package: Both Retinal photos screening & Visual field screening for $40 total.

Please select your choice below:

I choose to have ☐ Retinal photos ☐ Dilation ☐ Visual field ☐ Value package (retinal photos & visual field)

MEDICAL RELEASE: The undersigned authorizes the release of any medical information necessary to process this claim to the insurance companies listed previously. Additionally, the undersigned authorizes the release of any medical record information from other health care facilities to EyeRis Vision Center.

FINANCIAL AGREEMENT: The undersigned agrees to pay in full at the time of services, present insurance information for the filing of claims, and to honor a payment agreement plan until the balance is paid in full. The undersigned further understands that the office will submit itemized statements to the insurance companies as a courtesy to the patients and that by his/her signature, the insurance companies are authorized to make the payment directly to the practice. The undersigned, however, does accept the ultimate responsibility for payment and services not covered by insurance companies for any eye services and testing performed. In the case the undersigned is unwilling to pay the our office, we will send the statement to a Collection Agency. An additional 30% fee will be added to the statement balance, which is subject to change without prior notice. The undersigned understands all professional services and fees are non-refundable.

REFRACTION POLICY: Refraction is the process of determining the eye's refractive error, or need for corrective spectacle. It is an essential part of an eye examination, but is NOT a covered benefit by Medicare or certain Medical insurances. Office fee for the refraction is collected in addition to the patient's co-pay at the time of the visit.

ACKNOWLEDGMENT: A copy of EyeRis Vision's HIPPA & Notice of Privacy Notice is provided to me (attached on this clipboard). I have read, understand, and agreed to all the information above.

Patient's Name ____________________________________ Signature___________________________ Date______________
(If patient is a minor, Guardian's name & signature)