Welcome to The Landings Eye Care

Please fill out this form as accurately as possible. The information provided will be used to help better meet your needs.

When you are finished, please return this paperwork to the front desk along with your medical insurance card and photo ID.

Name:_____ Date:_____

Preferred Name:_____ Phone: _____ Home/ Work/ Cell

Address:_____

City, State, Zip:_____ Date of Birth:_____

Email address:_____

Sex: □ M □ F □ Prefer not to answer Are you a previous patient? □ No □ Yes

Vision Plans: □ VSP □ MetLife □ Eyemed □ Spectera □ BlueView □ Aetna □ Self

Vision plan ID number_____ (date of birth and last 4 of the social security number of the primary beneficiary if you do not know the ID number)

Medical Insurance Plan □ Tricare Prime □ Tricare Select □ Anthem/Blue Cross □ Cigna □ Humana

□ Medicare □ Aetna □ United Health Care □ Other_____

Insurance member ID number_____

Insurance Group ID number_____

Your Vision or Medical Insurance

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. I understand I will be held responsible for the services I will be receiving. I further understand that payment is due at the time of these services. In the event it becomes necessary to assign this account for collections or that any costs are incurred for collection of my past due account, I agree to be responsible for all costs of collection including a reasonable attorney fee. I authorize payment of medical benefits to the physician or supplier for services rendered. I hereby authorize the physician and/or staff to release any information to release any information required to process this claim

Patient/ Parent Signature _____Date_____

Returns and Refunds

I understand that Landings Eye Care will not provide any refunds for services rendered except in the case of overpayment by the patient. I understand there will be a restocking fee of 20% for any returns on frame purchases. There are no refunds for eyeglass lens purchases as these are custom made for each patient and cannot be used again. Contact lenses may be returned within 90 days of purchase if boxes are unopened and unmarked. I understand that any prescription adjustments for eyeglasses, must be made within 30 days of purchase.

Patient/ Parent Signature _____Date_____

THE LANDINGS EYE CARE

PATIENT MEDICAL HISTORY

Occupation:_____ Last Eye Exam:_____ Last Medical Exam:_____

Who is your primary care physician? _____

Do you or anyone in your immediate family have any of the following? (Please check all that apply)

Self/Family			Self/Family			Self/Family		
☐	☐	Blindness	☐	☐	Kidney Disease	☐	☐	High Cholesterol
☐	☐	Cataracts	☐	☐	Arthritis	☐	☐	Respiratory Disease
☐	☐	Glaucoma	☐	☐	Thyroid Disease	☐	☐	Stroke
☐	☐	Crossed/Lazy Eye	☐	☐	Heart Disease	☐	☐	High Blood Pressure
☐	☐	Macular Degeneration	☐	☐	Liver Disease	☐	☐	Cancer _____(Type)
☐	☐	Retinal Disease	☐	☐	Diabetes	☐	☐	Autoimmune disease
☐	☐	Seasonal Allergies	☐	☐	Anxiety/Depression			

Are you pregnant or breastfeeding? □ No □ Yes If you are pregnant, how many weeks? _____

Please list any **medications** you are currently taking including eyedrops: _____

_____

_____

We ask you for this information as some medications and health conditions affect your eye health and vision.

Are you **allergic** to any medications? □ No □ Yes, please list:_____

Please list any eye surgeries that you have had. _____

Are you experiencing any of the following? (Please check all that apply)

☐ Blurred Vision	☐ Burning	☐ Sandy/Gritty Feeling	☐ Double Vision
☐ Loss of Vision	☐ Eye Pain	☐ Watery Eyes	☐ Glare
☐ Dry Eyes	☐ Floaters	☐ Frequent Headaches	☐ Redness
☐ Itchy Eyes	☐ Flashes of Light	☐ Sensitivity to Light	☐ Swelling

Do you currently wear glasses? □ Yes □ No How old are your **current** glasses?_____

How do you use your glasses: □ Full Time □ Part Time □ Distance □ Near □ Computer

Are you planning to have a contact lens examination today? □ Yes □ No

Have you worn contact lenses before? □ Yes □ No

THE LANDINGS EYE CARE

Retinal Screening Photos

A retinal screening is a non-invasive diagnostic tool that takes an image of your optic nerve, macula, retinal blood vessels and retinal tissue. Why is it necessary? Early signs of many diseases occur inside of the eye including diabetes and hypertension. It can also help to better detect various medical conditions such as glaucoma and macular degeneration. This is not an alternative to dilation or other diagnostic testing.

We strongly encourage each patient to have a retinal screening performed as a baseline and to better monitor for changes each year. The screening is not covered by insurance. **The cost for this testing is $24**.

Please check one of the following:

☐ Yes, I would like to have the retinal screening photo performed.

☐ No, I do not want to have the retinal screening photo performed.

Informed Consent for Dilation of Eyes

Dilation of the pupils is the best way to have a complete eye examination. The purpose of dilating your pupils is to perform a more thorough examination of the health of your retina (the inside of your eye). A series of drops are placed in your eyes to enlarge the pupils. **There is no additional charge for this procedure.** Dilation may temporarily result in blurred vision, glare, and sensitivity to light for two to six hours. In most cases, only your near vision will be blurred. In rare cases, it may cause redness, headache, or foggy vision. Sunglasses will be provided for your safety and comfort.

Please check one of the following:

□ I do wish to have my eyes dilated and understand the side effects

□ I do not wish to have my eyes dilated. I understand that there may be diseases that cannot be ruled out and as a result, I do not hold Kelly Nilsson, OD, Family Eye Care of Columbus Inc, The Landings Eye Care or its associates liable for delay in diagnosis and treatment.

Reason that you do not wish to be dilated at today's visit_____

Patient/ Parent Signature _____Date_____

Please note if you are prediabetic or diabetic, you may need to return for a diabetic exam. This is not part of a routine exam billed under a vision plan.

THE LANDINGS EYE CARE

HIPPA

The law requires that Family Eye Care of Columbus, Inc make every effort to inform you of your rights related to your personal health information. By my signing below,

□ I acknowledge that I was given the opportunity to read, have read or had explained to me Family Eye Care of Columbus, Inc's Notice of Privacy Practice prior to any services offered. A copy may be provided for your records at your request.
□ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

Patient/ Parent Signature _____Date_____

I authorize Family Eye Care of Columbus, Inc to release my personal health information to the following individuals:

_____ _____

_____ _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization.
I authorize the release of medical information to my vision plan.

_____/_____
Patient Signature / Date

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed. I authorize the use of text and email.

_____/_____
Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.
_____ / _____

Representative Signature / Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor

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