4SIGHT iCARE PATIENT FORMS

PATIENT'S NAME: _____

-if a minor,
GUARDIAN'S NAME & RELATION:_____

To acknowledge that the "Notice of Privacy Practices" is available to you, **initial here:** _____

Receiving care from another eye doctor?___No___Yes (Name): _____

PRIMARY CARE PHYSICIAN & PHARMACY

Doctor Name:_____ Practice Name:_____
Office Phone: _____ Office Fax: _____
Pharmacy (name & location): _____

REASON(S) FOR VISIT (CHECK ALL THAT APPLY):

___Annual Eye Exam ___Eyeglasses ___Contact Lenses ___Medical Office Visit

THE iHEALTH WELLNESS EXAM:

At 4Sight iCare our mission is to help you SEE YOUR BEST. This means we endeavor to educate ways to protect your eyes & preserve healthy vision throughout your lifetime, provide a wide range of vision correction options from vision shaping retainers to the most modern multifocal lenses, invest in the most advanced equipment to evaluate and manage your eyes, and optimize your visual performance through ocular nutrition and/or vision training when appropriate. We bundle several screenings together to identify ways we can help beyond 20/20 that some but not all insurances cover completely at a $0 copay. The tests performed are determined by a number of factors: 1) only age appropriate tests approved by your eye doctor, 2) only CPT coded tests not billable to medical insurance on the same visit, 3) any insurance coverages/discounts applied, and 4) all advanced instrumentation deemed necessary by your eye doctor to provide you comprehensive eye care. Prior to insurance the cost is up to $97.

I am the responsible party for this patient account: __Yes__No (Name): _____

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE:_____ **DATE: ___/___/_____**

Give your 4Sight Care visit some 4-thought

CHECK ALL DISTANCES YOU WEAR GLASSES/CONTACTS:

Far **Reading** **Computer** **None**

How is your vision **with** your preferred vision correction at each distance?

Far:	Acceptable	May need improvement	Blurry
Near/Read:	Acceptable	May need improvement	Blurry
Computer:	Acceptable	May need improvement	Blurry

CHECK ALL THAT APPLY OVER THE PAST 3 MONTHS: score: (____)

In the last 3 months, how often have you experienced:	Constantly (3)	Daily (2)	Weekly (1)	Never (0)
Eye discomfort or itch?				
Burning sensation?				
Gritty/sandy sensation?				
Eye redness?				
Watery eyes?				
Fluctuating vision?				

CHECK ALL THAT YOU'RE EXPERIENCING NOW:

	Eye pain		Eyestrain		Headache
	Double Vision		Burning		Discharge
	Poor Night Vision		Bothersome Glare		Light Sensitivity
	Total Vision Loss		Other: _____		**None of these**

Indications for dilation include but are not limited to the following: pertinent family/personal medical history, recent eye/head injury, or abnormal tests results. Not having a dilated eye exam when indicated and/or failing to attend a medical eye care visit may be detrimental to your health and vision.

Dilation is an important part of an eye exam. It opens the pupil to better evaluate eye health, but it has temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only drive once comfortable with your vision.

Pupil dilation is not recommended for patients who are pregnant, nursing, or allergic to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide).

Initial which best represents your wishes:

_____ **NO** dilation eye drops today. If medically indicated, I shall schedule it to be done.

_____ **Discuss** dilation with my doctor **if medically indicated**. This may add up to 35 minutes.