WELCOME TO EYE & EAR

BOYNTON BEACH / PALM SPRINGS

Last Name _____ First Name _____

Male _____ Female _____ Date of Birth _____ Age _____ SS# _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Telephone (_____) _____ Alternate Telephone (_____) _____

Employer _____ Occupation _____

Hobbies _____ Sports _____

Primary Vision Care Plan _____ ID # _____

Other Health Plan _____ ID # _____

Insured's First Name _____ Insured's Last Name _____

Insured's SS # _____ Insured's Date of Birth _____

EMAIL ADDRESS: _____

How did you learn about our office?

❑ Walk By ❑ Insurance Plan ❑ Yellow Pages ❑ Other _____

❑ Doctor ❑ A Previous Patient ❑ Advertisement

Name of person who referred you _____ How do you know each other? _____

HEALTH HISTORY	Self	Family
Blindness	❑	❑
Cataracts / Cataract Surgery	❑	❑
Color Blindness	❑	❑
Crossed or Lazy Eye	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Retinal Disease	❑	❑
Vision Correction Surgery	❑	❑
Asthma / Lung Disorder	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Thyroid Problems	❑	❑

Are you Pregnant? ❑Yes ❑ No

Drug Allergies? ❑Yes ❑ No

If Yes, list them _____

EYEGLASSES

YOUR GLASSES ARE?

❑ With you ❑ Home ❑ Lost / Broken

HOW OLD ARE THEY?

❑ 1-2 yrs ❑ 3-4 yrs ❑ Over 4 yrs

YOU WEAR THEM?

❑ All the time ❑ Sometimes ❑ Rarely ❑ Never

ANY PROBLEMS SEEING WITH YOUR GLASSES?

❑ Far away ❑ Up close ❑ Not sure ❑ No

ARE THEY?

❑ No Line Bifocals ❑ Bifocals ❑ Single Vision

❑ Distance glasses ❑ Reading glasses

❑ Computer glasses

CONTACT LENSES

DO YOU WEAR CONTACT LENSES?

(CHECK ALL THAT APPLY)

❑ No ❑ Yes ❑ Soft ❑ RGP / Hard ❑ DailyWear

❑ Extended Wear ❑ Colors ❑ Disposables

❑ Daily ❑ 2 week ❑ Monthly ❑ Quarterly

❑ Torics(astigmatism) ❑ Bifocals ❑ Monovision

❑ Reading glasses over contacts

❑ Brand and power if known **RT** _____

LT _____

YOU LAST HAD YOUR CONTACTS IN?

❑ Now ❑ Days ❑ Weeks ❑ Months ❑ Years

ANY PROBLEMS SEEING WITH YOUR CONTACTS?

❑ Yes ❑ No ❑ Not sure

Reason for today's visit?

❑ Annual exam ❑ New Glasses ❑ Contact Lenses ❑ Red Eye ❑ Other _____

Date of Last Eye Exam _____ With Dr. _____ City / State _____

List any MEDICATIONS you are taking? _____

Describe any injury or surgery to your eyes or any information about your eyes that you would like us to know: _____

PLEASE SEE NEXT PAGE ➡

DILATED FUNDUS EXAMINATION INFORMED CONSENT

DILATION OF THE PUPIL is required to be performed on all new patients during the initial visit to this office. Eye drops are used to enlarge the pupils. This allows the doctor to check for cataracts, glaucoma, retinal tears and other conditions that may result in loss of vision. Your vision for driving and especially reading may become blurry, and make your eyes sensitive to light for about 4-5 hours. Disposable sunglasses are available upon request. There is no additional fee for this test.

Please check (✓) one:

_____ **I DO** want to have my eyes dilated at this time and understand my vision may be impaired.

_____ **I DO NOT** want to have my eyes dilated at this time because _____. I understand that I am releasing Dr. Barry A. Frankel & Associates from any liability by not having the exam.

_____ **I WILL RESCHEDULE** an appointment for the dilation at a future date.

VISUAL FIELD SCREENING INFORMED CONSENT

Our office recommends a new **Computerized Visual Field Screening** every year to all of our patients. This test can aid in the early detection of the following problems: MACULAR DEGENERATION, BRAIN TUMORS, DIABETIC CHANGES, GLAUCOMA, MULTIPLE SCLEROSIS, and RETINAL DETACHMENT. IT IS ESPECIALLY IMPORTANT IF YOU HAVE BEEN HAVING **HEADACHES,** OR HAVE FAMILY MEMBERS WITH ANY OF THE ABOVE PROBLEMS.
THERE IS A NOMINAL FEE OF $10 FOR THIS TEST.

Please check (✓) one:

_____ **I DO** want to take this test at this time _____ **I DO NOT** want to take this test at this time

DIGITAL RETINAL IMAGING INFORMED CONSENT

Our office recommends a new state-of-the-art diagnostic procedure called ***Digital Retinal Imaging***. This procedure consists of capturing an image of the inside (retina) of your eye using a specialized digital camera. This is not an X-ray and nothing will touch your eye. This procedure can aid in the early detection as well as following eye problems such as DIABETIC RETINOPATHY, MACULAR DEGENERATION, GLAUCOMA, PRECANCEROUS LESIONS AND RETINAL BREAKS.
THERE IS A NOMINAL FEE OF $25 FOR THIS TEST.

Please check (✓) one:

_____ **I DO** want to take this test at this time _____ **I DO NOT** want to take this test at this time

I, _____ _____ _____
Patient's Name (Please Print) **Patient's / Parent's Signature** **Date**
hereby acknowledge receipt of Barry A. Frankel & Associates' Notice of Privacy Practices given to me. In addition, I authorize this office to release any information needed to expedite insurance claims. I understand that I am responsible for all charges not covered by my vision insurance.

NOTICE OF PATIENT RESPONSIBILITY POLICY

❒ FOR PATIENTS WITH VISION PLANS:

- **SERVICES PROVIDED WITH OR WITHOUT AUTHORIZATION:**
  As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services and/or material rendered to me, if for any reason, my vision plan carrier denies or does not cover my claim for these services or materials.

- **COPAYS:**
  I understand that I am responsible to pay all co-payments at the time of service. Co-payments cannot be waived at any time by the providers of Eye & Ear.

❒ FOR MEDICARE PATIENTS ONLY:

- **MEDICARE DEDUCTIBLES:**
  If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payments in a timely manner, no more than 30 days after I have been notified by my insurance and/or my provider. Yearly deductibles cannot be waived at any time by the providers of Eye & Ear. This years Medicare Deductible is **$147.00**.

- **MEDICARE COVERAGE ALLOWANCES:**
  Medicare reimburses our office 80% of the approved amount for services. The remaining **20%** is your responsibility. Our office may elect to bill you directly or bill your supplemental insurance plan if you carry it.

- **MEDICARE REFRACTION INFORMED CONSENT:**
  THE REFRACTION is one of the most important parts of your eye exam today. This is the part of the exam by which the doctor will determine whether your vision can be improved in any way by a new eyeglass prescription. The refraction is **NOT** a covered service by Medicare and many other insurance plans as they only cover medical services. These plans consider refraction a vision service and not a medical service. Our office fee for refraction is **$35.00.** Unless you have a supplemental plan that automatically covers the refraction fee, this fee is collected at the time of service. Should your plan pay us for the refraction, we will reimburse you accordingly.

  Please check (✓) one:

  _____ **I DO** want to have the refraction at this time and understand that I am financially responsible.

  _____ **I DO NOT** want to have the refraction at this time. I understand that without the refraction, the doctor may not be able to fully assess the health and function of my eyes. As a result, I will not have a valid eyeglass prescription at the end of today's visit.

Please check (✓) one:

_____**I AGREE TO PAY:** I have read the above and I acknowledge for today's visit that I will assume full financial responsibility for services and/or material rendered to me, if for any reason, my vision plan carrier denies or does not cover my claim for these services or materials.

_____**I REFUSE SERVICE:** I have decided not to have the service/material rendered because I am not willing to be personally responsible for the payment.

_____ _____/_____/_____

Patient's / Parent's Signature **Date**