WELCOME TO EYE & EAR

PALM SPRINGS

Last Name_____ First Name_____

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

Street Address _____ Apt #_____

City _____ State_____ Zip Code_____

Home Telephone (_____)_____ Cell Phone (_____)_____ ❑ Texting Ok

Employer _____ Occupation _____

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: _____ Would you like monthly promotion & sale email? ❑ Yes ❑ No

How did you learn about our office?

❑ Walk By ❑ Insurance Plan ❑ Internet/ Social Media ❑ 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?

❑ Progressive ❑ Bifocals ❑ Single Vision

❑ Distance glasses ❑ Reading glasses

❑ Computer glasses

LIFESTYLE QUESTIONNAIRE

Please answer the following questions, these questions will help our staff better understand your eyewear needs.

Yes **No** Number of hours spent on a computer each day. If yes, how many hrs? ___

Yes **No** Do you have prescription sun wear?

Yes **No** Are you bothered by glare or night driving?

Yes **No** Do you play sports or have any hobbies? If so list them _____

Yes **No** Do you have more than 1 pair of current Rx eyewear?

Yes **No** Are you a contact lens wearer?

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 ➡

OPTOMAP ULTRA-WIDEFIELD RETINAL IMAGING INFORMED CONSENT

As part of our commitment to provide you with the most comprehensive eye care, we offer advanced high-definition ultrasound images which allow our doctor to gain a better understanding of any dangerous conditions that may be developing in your eyes.

Many eye problems can develop without warning and progress without symptoms. In the early stages, you may not notice a change in your vision, but sight threatening conditions such as retinal detachments, macular degeneration, glaucoma, and diabetic retinopathy can be detected with a thorough evaluation of the retina, using the Optomap Retinal Exam.

The Optomap Retinal Image Exam is a simple procedure that will help our doctor detect common eye diseases. It will also provide our doctor with a permanent baseline record of your retinal examination for comparison during future exams. Our doctor encourages all patients to undergo this valuable test as part of your annual eye health evaluation, and particularly for any individuals with any of the following:

- Spots, floaters, or flashes
- Hypertension
- Diabetes
- Eye pain/ Headaches
- History of head or eye trauma
- Family history of Glaucoma
- Family history of Macular Degeneration
- Strong eyeglass prescription

Our fee for the Retinal Imaging is _____.

_____**I DO** wish to participate in the advanced retinal imaging to assist in early detection of eye disease, and understand I am responsible for charges not covered by my insurance.
_____**I REFUSE** to participate in the advanced retinal imaging procedures and release Eye and Ear from any liability for future vision loss from conditions this screening test may have detected.

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 $_____ 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

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 have my regular examination today** and reschedule for dilation on a future date. (There will be an office visit charge of _____).

I, _____ _____ _____ ___/____/_____
Patient's Name (Please Print) Parent's Name (Please Print) Patient's / Parent's Signature Date

I 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 INSURANCE 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 year's Medicare Deductible is **$_____.**

- **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 **$_____.** 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 Name (Please Print)	**Parent's Name (Please Print)**	**Patient's / Parent's Signature**	**Date**