Bender eyecare

9925 Haynes Bridge Rd. #710, Johns Creek, GA 30022 Tel: 770-740-2000

PATIENT INFORMATION

LAST NAME	FIRST NAME		D.O.B. / /
ADDRESS		CITY	STATE ZIP
HOME PHONE	CELL PHONE	EMAIL	

INSURANCE

VISION INSURANCE	**MEMBER ID**
PRIMARY INSURED NAME	PRIMARY INSURED D.O.B. / /
MEDICAL INSURANCE	**MEMBER ID**
PRIMARY INSURED NAME	PRIMARY INSURED D.O.B. / /

MEDICAL INFORMATION

REASON FOR TODAY'S VISIT (CIRCLE ALL THAT APPLY):
REGULAR EXAM / GLASSES / CONTACT LENSES / EYE INFECTION / INJURY / OTHER:

DO YOU NEED A CONTACT LENS EXAM?
PRICING FOR EXAM AS FOLLOWS: MULTIFOCAL $135 / TORIC $115 / STANDARD $85.
YOUR INSURANCE MAY COVER ALL OR A PORTION OF THESE COSTS.

DO YOU WEAR CONTACT LENSES? Y / N **DO YOU SLEEP IN THEM?** Y / N
WHAT BRAND?

PLEASE CIRCLE ANY PROBLEMS YOU ARE EXPERIENCING WITH YOUR CONTACT LENSES:
DRYNESS / DISCOMFORT / REDNESS / BLURRED VISION / OTHER:

PLEASE INDICATE IF YOU WOULD LIKE TO DO AN O.C.T. RETINAL SCAN/PHOTO. THE COST FOR THIS TEST IS $50.
O.C.T. (OPTICAL COHERENCE TOMOGRAPHY) IS A NON-INVASIVE PROCEDURE WHICH GENERATES A PICTURE OF YOUR RETINA.
CENTRAL RETINAL DISEASE CAN OFTEN BE DETECTED EARLIER.

PLEASE LIST ALL KNOWN ALLERGIES:

PLEASE LIST ALL CURRENT MEDICATIONS:

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

	SELF	FAMILY		SELF		SELF		SELF		SELF
DIABETES			HEART DISEASE		RETINAL DETACHMENT		CATARACTS		REDNESS	
HIGH CHOLESTEROL			ARTHRITIS		BLURRED VISION		BURNING / STINGING		DOUBLE VISION	
HIGH BLOOD PRESSURE			CANCER		DRYNESS		EYE PAIN / SORENESS		FLASHES OF LIGHT	
GLAUCOMA			KIDNEY DISEASE		FLOATERS / SPOTS		WATERING / TEARING		ITCHY EYES	
MACULAR DEGENERATION			MULTIPLE SCLEROSIS		TIRED EYES		CROSSED EYES		HEADACHES	
			RESPIRATORY PROBLEMS		BLINDNESS / VISION LOSS		LAZY EYE		ANEMIA	

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FINANCIAL POLICY

I understand that full payment is due at the time of service. This includes any exam fees or copays, as well as all materials ordered (frames, lenses, contact lenses).

I accept that there are no refunds for frames or lenses, due to the custom nature of prescription orders. Contact lenses can be returned if unopened and not expired, with a $8/box restocking fee. There are no refunds for physician services.

INSURANCE AUTHORIZATION

I understand that I am responsible for any portion of my bill not covered by insurance, and I agree to pay for all services rendered to me or my dependents.

I authorize Bender Eyecare, Inc. to release any information (including but not limited to diagnoses, treatment plans, exam records, etc.) rendered to me or my dependents, to third party payers and/or healthcare practitioners, as needed.

PATIENT OWN FRAME WAIVER

We can make new prescription lenses for your own frame if it is in good condition. We pledge to take the utmost care in handling it, but occasionally due to wear and tear or age of the frame, the material can be brittle. We can assume no warranty against breakage.

HIPAA CONSENT

I acknowledge consent of HIPAA authorization.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________

For your convenience we accept cash or credit cards. There will be a 3% surcharge for all American Express payments.