THOMAS VISION CLINIC

Exceeding Your Expectations

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Office Use Only ☐ Optomap ☐ Dilation ☐ Refusal ☐ Refraction ☐ Eye Health ONLY

☐ Male ☐ Female

Race: ☐Asian ☐African American ☐Hispanic ☐White ☐Native American ☐Pacific Islander ☐Other

First Name Mi Last Name Preferred Name

Mailing Address City State Zip

Social Security # Date of Birth E-mail address

Home Phone Day Phone Cell Phone

Patient Status: ☐ Minor (17&younger) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Guardian/Responsible Party (if other than patient):

First Name MI Last Name Phone Number

Primary Insurance: _____
Company Member/Sponser ID # Member Date of Birth

Secondary Insurance: _____
Company Member/Sponser ID # Member Date of Birth

Primary Care Physician: _____

Pharmacy: _____

Contact Lens Exams

Please keep in mind that contact lenses are considered medical devices and require additional follow-up care to ensure proper fit. The professional fee for the fitting of contact lenses is separate from & additional to the eye health exam. If you opt to have an eye exam without a contact lens fitting, you will receive a prescription for glasses only.

Patient Name: _____

AUTHORIZATION & ACKNOWLEDGEMENT

Release of Information
I hereby authorize Thomas Vision Clinic to release any information necessary to my insurance company to expedite claims for payment. I authorize the release of medical information for the purpose of patient referral should I be referred.

Signature: _____ Date: _____

Patient Financial Agreement
I agree to be responsible for my financial portion of today's services including copays, deductibles & all non-covered procedures I elect to have performed. A copy of the financial disclosure statement is available to me upon request.

Signature: _____ Date: _____

Medical Authorizations
If discussed, I authorize the provision of medical services which are determined by Dr. Cowan to be in my best interest of care other than those I have previously refused in writing.

Signature: _____ Date: _____

Notice of Privacy Practices
I have reviewed the Thomas Vision Clinic Privacy Practice Notice that describes how my information may be disclosed. A copy of this notice is available to me upon request.

Signature: _____ Date: _____

Refraction Authorization
Refraction is the process of determining one's need for corrective eyewear (glasses & contact lenses). This procedure is not covered by Medicare or most insurances. **A fee of $20.00** is to be collected from the patient in addition to any copays or deductibles. Patients who are primarily covered by VSP, Tricare PRIME, or children 20& younger with Medicaid are not responsible for this fee, as these plans allow for the refraction.

I understand my financial responsibility and choose to have the refraction performed.

Signature: _____ Date: _____

Retinal Exam Authorization
Retinal Examinations are essential when evaluating eye health, visual development, progression of eye diseases, & systematic diseases such as hypertension, diabetes, stroke, & MS. These conditions are near impossible to detect without dilation or the Optomap.

Please select the retinal exam you want performed:

☐ Children 7 & younger must be dilated in order to determine the need for vision correction. No extra charge.

☐ Optomap Imaging – Scan that allows for a wider view of the retina without dilation. No visual aftereffects. The cost for this service is **$29.00** in addition to any copay& refraction fee. NOT COVERED BY INSURANCE

☐ Dilation - Manual examination through the pupil with the use of dilating eye drops. Aftereffects include short term blurred vision & light sensitivity. No extra charge

Signature: _____ Date: _____

Patient Name: _____

Eye & Visual Assessment

Reason for your visit? □ Glasses □ Contacts □ Eye Injury □ Yearly Eye Health Exam

Eye History

Check all that apply

- □ Glaucoma
- □ Cataract
- □ Macular Degeneration
- □ Retinal Detachment
- □ Eye Trauma
- □ Infections
- □ Eye Surgery
- □ Diabetic Retinopathy

Current Visual Problems

Check all that apply

- □ Distance Blurry
- □ Up Close reading Blurry
- □ Headaches
- □ Burning
- □ Tearing/watering
- □ Dry/Sandy/Gritty feeling
- □ Cloudy Vision
- □ Floaters/Spots
- □ Loss of side vision
- □ Loss of vision
- □ Light/Glare sensitivity
- □ Double vision
- □ Color vision

Family Eye History

Check all that apply

- □ Glaucoma
- □ Macular Degeneration
- □ Retinal Detachment
- □ Color Blindness
- □ Blindness
- □ Diabetic Retinopathy

Medical Assessment

Patient Weight: _____ lbs Patient Height: _____ ft _____ inches

Past Major Surgeries: □ None

_____

Current Medications: □ None

_____

_____

Current Health Issues (i.e. high bp, diabetes, cholesterol, depression, etc): □ None

_____

_____

Drug or Food Allergies: □ None

_____

Do you consume alcoholic beverages: □ Never □ Occasionally □ 1 per day □ 2-3 per day □ 4+ per day

Smoking statues: □ Never □ Occasionally □ ½ pk daily □ 1 pk per day □ 1+ pks per day □ Quit in _____