EyeShop Optical Center

Thank you for choosing our office. Please take a moment to complete the following information.
If you have any questions, please do not hesitate to ask.

◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms. ◯ Male ◯ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Day Phone (_____)_____ Mobile Phone (_____)_____ Birthdate _____ /_____ /_____ Social Security Number _____ /_____ /_____

Email address _____ Occupation _____

Employer _____ If child, parent's name _____

Patient Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you currently wear glasses? ◯ no ◯ full-time ◯ part-time reading ◯ part-time distance
Do you currently wear contact lenses? ◯ no ◯ yes If yes, which type? ◯ soft ◯ gas permeable
How often do you replace your contact lenses? ◯ daily ◯ every two weeks ◯ monthly ◯ quarterly ◯ yearly
Are you interested in updating your contact lens prescription today? ◯ yes ◯ no
(please note: there are additional fees associated with a contact lens exam)

Primary Insurance Information

Please give your card to the receptionist.

Primary member name _____ Birthdate _____ Patient Relationship to Insured (Self, Spouse, Child, Other) _____

Please Read:
I authorize EyeShop Optical Center to bill my vision and/or medical insurance for services rendered and request that all payments be made directly to the vision care provider. As your optometric care provider, our relationship is with you, our patient, and not with your insurance company. I understand that I am responsible for any insurance co-payments and unpaid portions the insurance denies or does not cover. We kindly request that professional services be paid for at the time rendered. When vision insurance is not involved, materials are to be paid in full at time of purchase.

Signature _____Date _____
Relationship to patient (if patient is a minor or patient is unable to sign): _____

Retinal Photography and Dilation Consent
Our Doctor routinely performs pupillary dilation to check for cataracts, macular degeneration, glaucoma, and other visual pathway diseases that may lead to loss of sight. This requires the use of drops and usually takes approximately 15 additional minutes. Some people may experience blurred vision up close and light sensitivity for a few hours. Would you like to have your eyes dilated as part of your comprehensive eye examination today? ◯ yes ◯ no (Initial) _____

We also offer retinal photography, a technologically advanced, painless procedure that consists of taking a photograph of the back part of your eye (the retina), and is suggested for both adults and children. This permanent record is valuable in assessing the health of your eyes and will serve as a baseline with which to compare as we follow your health in the future. In most cases DILATION IS NOT NEEDED for retinal photos. There is a $25 fee associated with this procedure that is not covered by insurance. Would you be interested in retinal photography today? ◯ yes ◯ no (Initial) _____

Acknowledgement of Receipt of Privacy Practices
I acknowledge that I reviewed/received a copy of EyeShop Optical Center Notice of Privacy Practices.

Signature _____Date _____