COMPLETE FAMILY EYECARE AND OPTIQUE, P.C.

DR. SCOTT BAYLARD DR. KRISHAN BHIMA DR. ALJABI

Welcome to Complete Family Eyecare. Thank you for choosing us for your eye care needs. Please take a moment to complete the following information as accurately as possible. If you have any questions, please do not hesitate to ask.

GENERAL INFORMATION

❑MR. ❑MS. ❑MRS. ❑DR. ❑REV.

❑MALE ❑FEMALE

NAME: (LAST, FIRST, MI)_____ Preferred name:_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE #: _____ OK TO TEXT? ❑YES ❑NO

WORK PHONE #: _____ HOME PHONE #: _____

DATE OF BIRTH: _____ AGE: _____ SSN#: _____

RACE: ❑AMERICAN INDIAN/ALASKAN NATIVE ❑ASIAN

❑BLACK OR AFRICAN AMERICAN ❑HISPANIC

❑NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ❑WHITE

MARITAL STATUS: ❑MARRIED ❑SINGLE ❑DIVORCED ❑LEGALLY SEPARATED ❑WIDOWED

EMAIL: _____

COMMUNICATION PREFERENCE: ❑EMAIL ❑POST ❑PHONE

PARENT/GUARDIAN: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

EMERGENCY CONTACT (NAME): _____

EMERGENCY PHONE #: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

❑ADVERTISEMENT ❑INSURANCE LISTING ❑INTERNET ❑DRIVE BY

❑PATIENT (PLEASE NAME): _____ ❑OTHER

GENERAL HISTORY

What is the main reason for today's exam? _____

When was your last **EYE** exam? _____ When was your last general **HEALTH** exam? _____

Past illnesses/injuries/surgeries: _____

Current Medications: **(including prescribed, over the counter or vitamins)** _____

_____

Medications you are allergic to: _____

Other allergies: (food, seasonal, etc…) _____

Do you wear contact lenses? ❑Yes ❑No
If **YES**, how many days per week? _____ Do you sleep in your contacts? ❑Yes ❑No
If **NO**, are you interested in wearing contacts? ❑Yes ❑No

Current occupation _____ Employer _____

EYE HISTORY Please check if you experience any of the following:

❑Headaches
❑Glare/light sensitivity
❑Tired eyes
❑Burning
❑Excessive tearing/watering
❑Eye pain or soreness
❑Irritation
❑Itching
❑Mucous discharge
❑Blurred Distance vision
❑Blurred Near vision
❑Distorted vision (halos)
❑Double vision
❑Sandy or gritty feeling
❑Other: _____

HEALTH HISTORY Please check if you have any of the following conditions and indicate type if applicable

❑Cardiovascular (heart disease, high blood pressure, stroke, etc.)
❑Respiratory (asthma, emphysema, etc.)
❑Blood/Lymph disorder (cholesterol, anemia, etc.)
❑Muscles, bones, joints (arthritis, etc.)
❑Skin (acne, skin cancer, etc.)
❑Neurological (multiple sclerosis, etc.)
❑Endocrine (diabetes, etc.)
❑Gastrointestinal
❑Immunologic (lupus, sarcoidosis, etc.)
❑Pregnant or nursing
❑Cancer
❑Psychiatric (anxiety, depression, etc.)
❑Other _____

FAMILY HEALTH HISTORY Please check if any of your immediate family members (list who) have any of the following and indicate type if applicable

❑Blindness or loss of vision
❑Strabismus (eye turn)
❑Macular degeneration
❑Retinal detachment
❑Glaucoma
❑Cancer
❑Cataract (s)
❑Arthritis
❑Other _____

OPTOS RETINAL IMAGING OR DILATION OF THE EYE

Our doctors recommend either Optos Retinal Imaging or dilation ***every year*** to check the internal health of the eye. ***Optos Retinal Imaging is $39.00 for both eyes. There is no charge for dilation if it is done today or within the next 30 days.***

PLEASE CHOOSE ONE OF THE FOLLOWING:

❑ I would like to have the Optos Retinal Imaging for $39.00
❑ I would like to have my eyes dilated: ❑today ❑within 30 days

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2350 Atlanta Hwy, Suite 110, Cumming, GA 30040 (678)965-5558

Patient Name: _____ **SSN#** _____

We are committed to meeting your health care needs. We would rather control billing costs than be forced to raise our fees. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

- All Professional services and materials are charged to the patient. The patient's portion is paid at the time services are rendered unless other arrangements are made in advance.
- You are ultimately responsible for payment of charges for services you receive from our office. Any payment dishonored by your bank will result in a $75.00 return check charge being added to your account.
- It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit.
- It is your responsibility to contact your insurance carrier to confirm that our Optometrists participate in your plan. If you see one of our doctors who is currently not on you plan, you will be responsible for payment in full.
- Payment from your insurance company will be paid directly to Complete Family Eyecare and Optique, P.C. We will file any secondary insurance with proof of insurance. Please understand that all benefits quoted to the undersigned are not a guarantee of payment by your insurance company and that final determination can be made only when the claim is processed.
- If your insurance plan requires a referral, it is your responsibility to obtain this referral prior to being seen by the doctor. If our office is required to obtain the referral for you, please notify our office 72 hours (3 business days) prior to the specialist visit so that we have ample time to acquire this information from your insurance company.
- If you miss your appointment you will be charged a NO SHOW fee at the rate agreed on between Complete Family Eyecare and your insurance company (an amount which your insurance company would have paid to us for the visit plus the amount of your co-pay or co-insurance) but a minimum of $70 for each appointment missed, no exceptions.
- Accounts 90 days old are subject to collection fees. You, the patient, accept responsibility for all fees incurred and agree that if it is necessary for Complete Family Eyecare to pursue collection activity on your account, either through a collection agency or an attorney, you, the client, shall be responsible for all costs of such collection activity, including but not limited to reasonable attorney's fees. Collection fees of 30% (thirty percent) will be added to the patient's account balance to cover such service fees.
- All record requests must be in writing and received by our office at least 72 hours (3 business days) prior to the date needed. Records over 10 pages will be mailed or emailed but not faxed.

Patient Signature _____ Date _____