Wake Forest eyecarecenter® OD, PA
Doctors Focused on You.

Welcome

Please have your medical insurance card and eyeglasses/ contact lenses at your appointment

Patient Demographics				
Last name	First name		MI	Nickname
Birth Date	Sex	Race		SSN
Address			City – State – Zip	
Cell Phone	Home Phone		Email	
Marital Status	Occupation		Employer	Work Phone
Insurance Subscriber/Responsible Party:			Subscriber ID No.:	
Who can we thank for referring you?			If not referred, how did you find us? Insurance - Internet Mailer – Advertisement – Drive By - Other	
Primary Care Physician:			Pharmacy/Location:	

Current Eye Concerns					
	Yes	No		Yes	No
Blurred or Double Vision			Floaters		
Eye Injury			Difficulty in low light		
Flashes			Difficulty while driving		

Contact Lens Services

Wake Forest Eye Care Center prescribes quality contact lenses to improve your vision and lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly.

New and existing contact lenses wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. For this reason, there are additional contact lens evaluation and service fees, which covers:

1) Specific curvature measurements of the corneas.
2) Evaluation of current and new lenses to ensure optimal fit, vision, and comfort.
3) Medical assessment of the cornea, tear film, and conjunctiva as they relate to the contact lens wear.
4) Instructions regarding safe contact lens wear, care, and proper cleaning and solutions.
5) Contact lens follow up fitting and care for up to 90 days after initial examination

I acknowledge the above and consent to contact lens evaluation, exam, and services	Yes	No

Consent for Treatment: I hereby authorize Wake Forest Eye Care Center to administer diagnostic and medical procedures as may be necessary.

Notice of Privacy Policy: I hereby acknowledge I have received notice of my rights under HIPPA as it applies to my visit at Wake Forest Eye Care Center.

Insurance: I hereby authorize Wake Forest Eye Care Center to file applicable insurance claims, including the release of any medical or other information necessary to process claims. I acknowledge that most insurance policies pay only a portion of total charges. Wake Forest Eye Care Center does not guarantee the accuracy of benefit information provided to us by insurance companies. Patient is responsible for any and all remaining balances not covered by insurance. Patients are responsible for all late penalties, collections fees, and returned check fees.

Patient Rights: Wake Forest Eye Care Center guarantees the right to itemized receipt(s), exam records, and current prescriptions upon request.

Signature: _____ Date: _____

Medical

Please list any medications including eye drops, over the counter medications, and supplements you are currently taking:

Please list any allergies:

Major Illness, Injury, or Surgery:

Are you currently pregnant or nursing?

Do you smoke?	When did you start? How many per day?
Do you drink alcohol?	How much? Frequency?

Please include Past and Current conditions

Ocular Problems	Self	Mother	Father	Sibling
Glaucoma				
Dry Eye				
Cataract				
Amblyopia (Lazy Eye)				
Macular Degeneration				
Inflammatory Disease				
Retinal Detachment				
Strabismus (Eye Turn)				
Neurological	Self	Mother	Father	Sibling
Headaches				
Cerebral Palsy				
Multiple Sclerosis				
Tumor				
Epilepsy				
Cardiovascular	Self	Mother	Father	Sibling
Vascular Disease				
Stroke				
Congestive Heart Failure				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Endocrine	Self	Mother	Father	Sibling
Diabetes – Type 1				
Diabetes – Type 2				
Thyroid (Hypo/Hyper)				
Hormonal Dysfunction				

Psychiatric	Self	Mother	Father	Sibling
Depression				
Anxiety				
Constitutional	Self	Mother	Father	Sibling
Cancer				
Developmental				
Immunologic	Self	Mother	Father	Sibling
Rheumatoid Arthritis				
Lupus				
Blood/Lymph	Self	Mother	Father	Sibling
Anemia				
Blood Disease				
Genitourinary	Self	Mother	Father	Sibling
Prostate Disease/Cancer				
STD				
Kidney Disease				
Gastrointestinal	Self	Mother	Father	Sibling
Colitis				
Crohn's Disease				
Ulcer				
Irritable Bowel Syndrome				
OTHER	Self	Mother	Father	Sibling