ABOUT YOU

If no information has changed since your last exam, please check the box and continue to insurance section ❑

Patient's Name *(Last, First, Middle Initial)*		**Gender** *(check one)* ❑ Male ❑ Female	**Date of Birth**	**SSN**
Street Address		**City**	**State**	**Zip Code**
Cell Phone	**Home Phone**	**Email**		
Marital Status *(check one)* ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____		**Employer Name**		

PRIMARY INSURANCE

Insurance Name	**Member ID**	
If patient is policy holder, please check here ❑ If not, please continue.		
Policy Holder's Name	**Relationship to Patient**	
Gender *(check one)* ❑Male ❑Female	**Date of Birth**	**SSN**
Street Address		
City	**State**	**Zip Code**
Cell Phone	**Home Phone**	

SECONDARY INSURANCE

Insurance Name	**Member ID**	
If patient is policy holder, please check here ❑ If not, please continue.		
Policy Holder's Name	**Relationship to Patient**	
Gender *(check one)* ❑ Male ❑ Female	**Date of Birth**	**SSN**
Street Address		
City	**State**	**Zip Code**
Cell Phone	**Home Phone**	

EMERGENCY CONTACT

Contact's Name *(Last, First, Middle Initial)*	**Phone Number**	**Relationship to Patient**
Street Address	**City**	**State**	**Zip Code**

CONTINUE ON BACK

Medical History

Height: ___ft. ___in. **Weight: _____ lbs**

Do you currently, or have you ever, had any of the following conditions?
Please check all that apply.

Systemic		**Medications**
ADHD	❑	_____
Allergies	❑	_____
Arthritis	❑	_____
Asthma	❑	_____
Autism	❑	_____
Brain Tumor	❑	_____
Cancer: Type _____	❑	_____
COPD	❑	_____
Diabetes	❑	_____ Last Blood Sugar ____ Last HgbA1C _____
Head Trauma	❑	_____
Heart Attack	❑	_____
Hepatitis A❑ B❑ C❑	❑	_____
Hypercholesterolemia	❑	_____
Hypertension	❑	_____
Migraine Headaches	❑	_____
Multiple Sclerosis	❑	_____
Neuropathy	❑	_____
Parkinson's Disease	❑	_____
Rheumatoid Arthritis	❑	_____
Seizures	❑	_____
Stroke	❑	_____
Thyroid Disease	❑	_____
Other: _____		_____
Other: _____		_____

Ocular History	
Cataract	❑
Corneal Dystrophy	❑
Diabetic Retinopathy	❑
Glaucoma	❑
Keratoconus	❑
Macular Degeneration	❑
Ocular Hypertension	❑
Retinal Detachment	❑
Retinal Tear	❑
Other: _____	❑

Ocular Surgery	
Cataract Surgery	❑
Corneal Transplant	❑
Eye Muscle Surgery	❑
Intravitreal Injections	❑
LASIK / PRK / RK	❑
Punctal Plugs	❑
Retinal Laser	❑
Other: _____	❑

Past Medical Surgeries:
_____
_____
_____

Ocular Medications or Eye Drops:
_____
_____
_____

Allergies
*(Medications)*_____
_____
_____
_____
*(Non-medications)*_____
_____
_____
_____

Additional Medications or Vitamins:
_____
_____
_____

What brings you in today? (*please check all that apply)*

- Routine eye exam ❑ Yes ❑ No
- New Glasses ❑ Yes ❑ No
- Contact lens exam ❑ Yes ❑ No
- Other
    - Please explain:

_____

_____

_____

Do you have any concerns about your vision? ❑ Yes ❑ No

If yes, please specify which eye and explain your concerns and give an approximate time period of how long you have been experiencing this issue.

_____

_____

Do you…

- Currently wear glasses? ❑ Yes ❑ No
- Currently wear contact lenses? ❑ Yes ❑ No
- Perform fine or close-up work? ❑ Yes ❑ No
- Have trouble reading signs when driving at night? ❑ Yes ❑ No
- Experience any problems with fluctuating vision? ❑ Yes ❑ No
- Experience any problems concerning dry eyes? ❑ Yes ❑ No
- Experience any problems with floaters? ❑ Yes ❑ No

Are you…

- Outdoors all or part of the time? ❑ Yes ❑ No
- Bothered by glare from…?
    - Overhead lighting? ❑ Yes ❑ No
    - A computer screen? ❑ Yes ❑ No
    - Oncoming headlights at night? ❑ Yes ❑ No
- Sensitive in bright sunlight? ❑ Yes ❑ No

Approximately how many hours per day do you find yourself using digital devices? _____
How would you say your eyes feel at the end of the day (i.e. tired, dry, sore, etc.)? _____

CONTINUE ON BACK

DILATION CONSENT FORM

A DILATED FUNDUS EXAM IS RECOMMENDED ROUTINELY AT THE TIME OF YOUR INITIAL EXAM FOR BASELINE RECORDING AND USUALLY EVERY OTHER FULL EYE EXAM THEREAFTER (ABOUT EVERY 2-3 YEARS). DILATION ALLOWS THE DOCTOR A BETTER VIEW OF THE PERIPHERAL RETINA FOR DISEASE. IT SHOULD BE DONE ANNUALLY IF YOU HAVE ANY OF THE CONDITIONS LISTED BELOW:

IF YOU HAVE A HISTORY OF HIGH BLOOD PRESSURE, DIABETES, PAST RETINAL PROBLEMS (I.E., RETINAL DETACHMENTS/TEARS), EXTREME NEARSIGHTEDNESS. IT IS ALSO RECOMMENDED IF YOU HAVE EXPERIENCED SUDDEN CLOUDINESS OF VISION, ESPECIALLY IN ONE EYE, "CURTAIN OR VEIL-LIKE" OBSTRUCTION OF VISION, A SUDDEN ONSET OF MANY "FLOATERS" OR FLASHES OF LIGHT OFF TO THE SIDE OF YOUR VISION.

RISKS:

- SOME BLURRING OF VISION AND GLARE BECAUSE OF YOUR ENLARGED PUPILS FOR ABOUT 2 HRS (BUT UP TO 6 HRS). YOU SHOULD NOT OPERATE HEAVY EQUIPMENT OR DRIVE AN AUTOMOBILE UNLESS YOU ARE COMFORTABLE WITH YOUR VISION.
- DIFFICULTY WITH NEAR READING FOR 1-2 HOURS. THE FOCUSING ABILITY IMPAIRED AND MAY CAUSE A SLIGHT HEADACHE IF YOU TRY TO READ.
- INDUCED OCULAR HYPERTENSION. RARE CASES HAVE BEEN REPORTED IN WHICH REDNESS AND SHARP PAIN ARE EXPERIENCED BECAUSE OF INCREASED EYE PRESSURE. IF THIS HAPPENS CONTACT THE DOCTOR IMMEDIATELY.

CHECK ONE:

_____I UNDERSTAND THE ABOVE AND WOULD LIKE TO ACCEPT DILATION.

_____I UNDERSTAND THE ABOVE AND WOULD LIKE TO RESCHEDULE.

_____I UNDERSTAND THE ABOVE AND DECLINE DILATION AT THIS TIME. I UNDERSTAND THAT POTENTIAL FOR PARTIAL OR TOTAL LOSS OF VISION MAY EXIST AND, WITHOUT DILATION, MAY GO UNDETECTED.

NAME (PLEASE PRINT):_____

SIGNATURE:_____DATE:_____

PATIENT CONSENT FORM

PLEASE READ CAREFULLY:

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing the release of any information necessary to process my claims for medical or other insurance benefits.

I understand that it is my responsibility to pay Killeen Vision Source for the services and supplies provided regardless of any deductible, co-payments, or other variations in my individual insurance program. These are my rights and benefits under my insurance policy.

I understand that if for any payments for provided services and/or products is denied to Killeen Vision Source by my insurance, I will receive a bill in the mail and I am responsible for paying for these services or products furnished to me by this provider.

I understand that writing a check with insufficient funds is check fraud, and that all check fraud will be referred to the Bell County Attorney's office for collection. A $40.00 returned check fee will be assessed to me.

I give my permission to the Killeen Vision Source to release my information for the purpose of billing my claim to my carrier. Any information about my insurance or health is to be held in strict confidence for the sole purpose as noted.

Medicare/Medicaid:

If I have Medicare or Medicaid, the Killeen Vision Source agrees to accept assignment, and I authorize the Killeen Vision Source to bill my insurance carrier (providing any and all necessary information and documentation) for whatever benefits I am entitled.

Federal Law requires that we notify you when services to be provided may not be covered by them because it may not meet their guidelines. Vision exams are only covered if you have or found to have a medical condition requiring eye care. This document serves as notice that Medicare denies payment for this service; you will be responsible for payment.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the full Notice of Privacy Practices of Killeen Vision Source, contains a more complete description of the uses and disclosures of my health information and is available upon request. The law requires that Killeen Vision Source make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Killeen Vision Source's Notice of Privacy Practice and agree to continue my care with Killeen Vision Source under said terms.
- ☐ I was given the opportunity to read Killeen Vision Source's Notice of Privacy Practice and declined, but wish to continue my care with Killeen Vision Source under terms of Killeen Vision Source's the privacy policies.
- ☐ I have read or had explained to me Killeen Vision Source's Notice of Privacy Practice and do not wish to continue my care with Killeen Vision Source under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of the other reason described as:_____

By signing below I have read the above Patient Consent Form and Notice of Privacy Practices Acknowledgement, I do hereby acknowledge that I am familiar and fully understand the terms and conditions.

NAME (please print):_____

SIGNATURE:_____ Date:_____

CONTINUE ON BACK

YOUR KILLEEN VISION SOURCE IS PROUD TO OFFER OUR PATIENTS THE NEWEST TECHNOLOGY.

OCT EYE WELLNESS SCREENING TEST

THE OCT IS AN ADVANCED EYE SCAN THAT USES LIGHT WAVES TO SEE BENEATH THE SURFACE OF THE EYE. IT ALLOWS US TO SIMULTANEOUSLY TAKE A DIGITAL PHOTOGRAPH AND A 3D CROSS SECTION OF THE BACK OF YOUR EYE. THE SCAN IS NON-INVASIVE, PAINLESS AND CAN BE COMPLETED IN 60 SECONDS OR LESS.

THE OCT SCANS LAYERS OF THE RETINA THAT ARE INVISIBLE TO HELP DETECT THESE DISEASES:

1. AGE-RELATED MACULAR DEGENERATION
2. DIABETES
3. GLAUCOMA
4. MACULAR HOLES
5. VITREOUS DETACHMENTS

THE HEALTH OF YOUR EYES MATTERS TO YOU AND IT MATTERS TO US, TOO. THAT IS WHY WE ARE OFFERING THIS TESTS.

THE FEE FOR OUR WELLNESS SCREENING TEST IS $39.00. IF YOU WOULD LIKE TO ACCEPT THIS TEST, PLEASE SIGN BELOW.

X _____ DATE _____