



FULL NAME: _____

DATE OF BIRTH: ____/____/____

ADDRESS: _____

PREFERRED PHONE #: _____

EMAIL ADDRESS: _____

SOCIAL SECURITY #: _____

LAST EYE EXAM: _____

MEDICAL DOCTOR: _____

LAST MEDICAL EXAM: ____/____/____

OCCUPATION: _____

EMPLOYER: _____

MEDICAL INSURANCE (NAME & ID#): _____

VISION INSURANCE (NAME & ID#): _____

POLICY HOLDER NAME (IF DIFFERENT): _____

POLICY HOLDER DOB: ____/____/____

RELATIONSHIP TO PATIENT: _____

Who may we thank for referring you to our office: _____

OCULAR HISTORY

Do you wear glasses? No Yes If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? No Yes If yes, what brand? _____

How often do you wear them? _____ How frequently do you replace them? _____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

Are you having any vision problems? _____ If yes, please explain: _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

- | | | |
|---|---|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Flashes / Floaters | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Halos / Glare | <input type="checkbox"/> Excess Tearing / Watering |
| <input type="checkbox"/> Distorted Vision | <input type="checkbox"/> Dryness | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Mucous Discharge |
| <input type="checkbox"/> Eye Strain/Fatigue | <input type="checkbox"/> Burning | <input type="checkbox"/> Swelling of the Eyelids |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Itching | <input type="checkbox"/> Styes |

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

- | | | |
|--|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Crossed Eyes/Strabismus | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Lazy Eye/Amblyopia | <input type="checkbox"/> Other _____ |

MEDICAL HISTORY

List any medications you are currently taking (including over the counter and supplements): _____

Are you allergic to any medications? No Yes If yes, which ones: _____

REVIEW OF SYSTEMS Please check box if "yes" to any conditions you have or have had

ALLERGIC / IMMUNOLOGIC

Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC

- Vascular Disease
- Heart Disease
- High Blood Pressure
- High Cholesterol

CONSTITUTIONAL

- Developmental Disabilities
- Fatigue Syndrome

EARS, NOSE, MOUTH, THROAT

- Sinus Congestion
- Dry Throat / Mouth

ENDOCRINE

- Type 1 Diabetes
- Type 2 Diabetes
- Thyroid Disease

GASTROINTESTINAL

- Colitis/Crohn's Disease
- Ulcers
- Acid Reflux

GENITOURINARY

- Kidney Disease
- Ovarian / Uterine Cancer
- Prostate Cancer

HEMATOLOGIC / LYMPHATIC

- Anemia
- Bleeding Problems
- Breast Cancer

INTEGUMENTARY (Skin)

- Cancer
- Psoriasis/Eczema

MUSCULOSKELETAL

- Arthritis

Osteoporosis

Gout

NEUROLOGICAL

- Migraines
- Multiple Sclerosis
- Epilepsy
- Stroke

PSYCHIATRIC

- Anxiety
- Depression
- ADD/ADHD
- Mood Disorder

RESPIRATORY

- Asthma
- Bronchitis
- COPD
- Sleep Apnea

If you checked any of the above boxes or have a condition not listed, please explain further: _____

Are you pregnant or nursing? No Yes

FAMILY HISTORY Please check the box if "yes" (include parents, siblings, grandparents, & children)

Glaucoma

Cataract

Macular Degeneration

Retinal Detachment

Blindness

Crossed Eyes/ Lazy Eye

Diabetes

Cancer

Heart Disease

High Blood Pressure

Keratoconus

Signature: _____ Date _____ / _____ / _____



LANG FAMILY EYE CARE

HEALTH TESTING NECESSARY FOR PROPER PATIENT CARE

Your vision insurance is defined as a minimal or basic eye examination. There are two (2) vital health tests that have always been a part of our comprehensive eye health evaluation. In order to provide preventive eye health evaluations and preserve your sight by early detection of systemic (body) disease and eye disease, these tests must be performed on all patients annually. Your vision insurance does not cover the cost of these vital tests, yet they are extremely necessary.

RETINAL PHOTOGRAPHY- Taking yearly colored photographs of the inside of the eyes is much like a dentist x-raying your mouth annually. The retinal photos document the internal health of your eyes and allow for accurate yearly comparisons. Retinal photography establishes baseline health information, which will allow earlier diagnosis in the event your eye health changes in the future. It is strongly recommended for all patients and certainly important for anyone with a family history of glaucoma, diabetes, macular degeneration, and any other sight threatening diseases. These photos enable the doctor to detect early eye health changes so that early treatment may be instituted to preserve your sight.

VISUAL FIELDS- is one of the most state of the art medical eye tests available. The findings from this test enable doctors to determine if there is any retinal disease and if there is any disease process behind the eye all the way to the back of the brain. The visual field instrument tests peripheral vision paramount in driving and work related tasks. This test should be administered every year since the conditions looked for can develop in anyone at any time.

The reduced fee for both tests is \$30.00

The fee is due today - the day service is rendered.

Or, you may choose individual tests at the following rates:

Retinal Photography \$25

Visual Fields \$20

Note: A professional courtesy (savings) of \$15.00 when all tests are administered.

_____ YES- I choose to have all preventive health tests performed at \$30.00.

I understand the fees are due today.

_____ YES- I choose to have only: (check your choices)

_____ RETINAL PHOTOGRAPHY (\$25.00)

_____ VISUAL FIELDS (\$20.00)

_____ NO- I choose to neglect the health tests and I understand the medical risks involved.

If any questions or concerns regarding these procedures, please inquire with Dr(s). Lang.

Patient Signature (Parent or legal guardian under 18)

Date _____

Printed Name of Patient



LANG FAMILY EYE CARE

PAYMENT POLICY

Examination fee and copayments for materials are due at the time of service and must be paid in full prior to ordering. If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a service fee of \$25.00. Spectacle lenses and specialty contact lenses are custom made and tailored medical devices and therefore are non-refundable. We will happily troubleshoot any issues that may arise, and exchange or credit, as needed, in the first **30** days after the order has been dispensed.

I Hereby authorize my insurance carrier to make a payment directly to Lang Family Eye Care for any and all services rendered to me by Lang Family Eye Care. I understand that I am financially responsible for all charges whether or not covered by insurance.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

Patient Signature (Parent or legal guardian under 18)

Date _____

Printed Name of Patient

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I am aware of the Privacy Policy and Practices for Lang Family Eye Care that explains how my health information may be used and disclosed and how I can get access to that information. I understand that I am able to request a copy of this notice, or discuss any questions I may have regarding the privacy notice with my provider.

Patient Signature (Parent or legal guardian under 18)

Date _____

Printed Name of Patient



LANG FAMILY EYE CARE

CONTACT LENS POLICY

The purpose of your annual contact lens exam is to ensure the fit, comfort, and clarity of your contact lenses. The contact lens exam is separate from the routine vision exam, which is the determination of your eyeglass prescription.

Contact lens prescriptions are valid for one year from the date of your exam and cannot be renewed without an annual examination. If it has been one year or more since your contact lens exam, you will need a new examination to order contact lenses.

A contact lens fee will be charged annually. If your insurance company does not cover this fee in full, then payment or copayment will be required at the time of service. This fee is non-refundable.

The contact lens evaluation fee will cover the initial evaluation, as well as any follow up care necessary within the following **60 days**.

I have read the above information and understand the contact lens policy. I would like to be evaluated for contact lenses at this time.

Patient Signature (Parent/Guardian if under 18)

Date