Accent Eye Care

Date_____ Email _____
Patient Name - Last_____ First_____
Address_____ City _____ State_____ Zip_____
Age_____ Home Phone _____ Cell Phone _____
Work Phone _____ Occupation_____ Employer_____
Medical Insurance _____ Vision Insurance_____
Name of Primary Insured_____ **DOB**_____ **SSN**_____
Parent / Guardian if patient is a minor _____ School & Grade _____
Today's Visit: (Please check all that apply) ☐Glasses ☐Contact Lenses ☐Therapeutic/Vision Therapy
Please list main reason(s) for today's exam and any topics you wish to discuss: _____
_____

MEDICAL HISTORY Height _____ Weight _____

Please list below any current medications you are taking:

Medication	Reason	Medication	Reason

Drug Allergies_____
Please list any problems with your eyes or with your correction: _____
Please list any new medical problems or surgeries: _____
_____

	Illness	*Relative/Self*	*Illness*	*Relative/Self*	*Illness*	*Relative/Self*
Do you or any BLOOD relatives suffer from any of the following:	☐High BP		☐Cataracts		☐Glaucoma	
	☐Keratoconus		☐Diabetes		☐Macular Degeneration	
	☐Heart Disease		☐Retinal Detachment			

PUPIL DILATION

Dilated exams provide the doctor with a comprehensive view of the retina (back layer of the eye) and are essential in the early detection and prevention of many eye diseases. Eye drops are required and your near vision will remain blurred and light sensitive for several hours afterwards. When dilated, we advise you to exert caution when driving. Dr. Gong strongly recommends dilation yearly.
Please indicate if you wish to have the dilation test done today:
☐ Yes ☐ No ☐ Reschedule ☐ Discuss with Doctor

RETINAL PHOTOS

A retinal photo gives Dr. Gong a detailed picture of the back of your eyes. This can help detect conditions such as glaucoma, diabetes, hypertension, and retinal detachment, among many others. These photos will be saved in your file to compare to over the years.
Please indicate if you wish to have Retinal Photos done today:
☐ Yes ☐ No ☐ Discuss with Doctor

Payment is expected in full when services are rendered.
Eyeglasses and contact lenses must be paid for in full by the time of dispensing

Who is responsible for charges not covered by insurance? ☐ Self ☐ Other, (please name)_____

I authorize this office to release any information to third-party payers for billing purposes. I authorize and request my insurance company to pay my insurance benefits to Accent Eye Care. I acknowledge that I am financially responsible for any services/materials and claims not covered and /or denied by my insurance for myself and my dependents. Returned checks incur a $30 fee. Appointments not cancelled within 24 hours are subject to a $30 fee. Accent Eye Care is not responsible for previously used frames and/or lenses which are being reused or adjusted at my request. Eyeglass lenses and frames are non-returnable and non-refundable medical devices. Eyeglass frames are warranted only for manufacturer's defects one time within one year of purchase; shipping, handling and restocking fees will apply. Prescription accuracy is warranted and must be reported within 60 days from date of exam with a one time redo of lenses purchased here. Unmarked and unopened contact lens boxes may be exchanged within 60 days from date of exam, a restocking fee will apply. Contact lens fittings are non-refundable. I understand that all fees may be subject to change without notice. If the account is referred to a collection agency there will be a collection fee of up to 30% over the principle assessed and any applicable fees.

Signature_____ Date_____