



WILDWOOD EYECARE

1545 Powers Ferry Rd., Suite 240, Marietta, GA 30067
Phone: 770-952-6412 Fax: 770-953-2738

PATIENT INFORMATION & HISTORY

Thank you for choosing our practice for your eye care needs. PLEASE PRINT as you complete this form and do not hesitate to ask for assistance if you have any questions or concerns. We look forward to serving you.

Name _____ Nickname _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ Social Security # _____ E-mail _____

Please circle: Male / Female Married / Single Occupation _____ # Computer hours _____

Employer _____ Employment Status: Full-time / Part-time / Self-employed / Retired / Full-time Student

Vision Insurance _____ Medical Insurance _____ Medical Doctor _____

Primary Insured Member: Name _____ Birthdate _____ SS # _____

Previous Eye Dr. _____ Last Eye Exam _____ How did you hear about us? Insurance/ Phone book/ Friend/ Other _____

List of Family Members: _____

Reason for visit: Glasses / Contact Lenses / Eye Infection / Eye Injury / Eye Health Exam / Referral / Other _____

Do you have any known allergies (medical or environmental)? No Yes _____

Are you taking any medications? No Yes _____

Please check any of the following that applies to yourself or your immediate family members:

	Self	Family		Self	Family		Self	Family
Allergies	___	___	Blurred Vision	___	___	Anemia	___	___
Amblyopia / Lazy Eye	___	___	Burning / Stinging	___	___	Arthritis	___	___
Blindness / Vision Loss	___	___	Double Vision	___	___	Cancer	___	___
Cataracts	___	___	Dryness	___	___	Diabetes	___	___
Crossed eyes	___	___	Eye Pain/Soreness	___	___	Headaches	___	___
Eye Injury	___	___	Flashes of Light	___	___	Heart Disease	___	___
Glaucoma	___	___	Floaters / Spots	___	___	High Blood Pressure	___	___
Macular Degeneration	___	___	Foreign Body Feeling	___	___	High Cholesterol	___	___
Retinal Detachment	___	___	Itching	___	___	Kidney Disease	___	___
Retinal Disease	___	___	Tired eyes	___	___	Multiple Sclerosis	___	___
Red eyes	___	___	Watering / Tearing	___	___	Respiratory Problems	___	___
Other: _____								

Do you wear glasses? No / Yes How old are the present glasses? _____ What type? Single vision / Bifocal / Trifocal / Progressive / Readers

Do you wear contact lenses? No / Yes How old are your current contacts? _____ How often do you dispose your contacts? _____

What brand of contacts do you wear? _____ Do you sleep in them? No / Yes How many nights a week? _____

What solutions do you use? _____ Are you experiencing any problems with contacts? Dryness / Discomfort / Redness / Blurred vision

Are you interested in LASIK or other types of refractive correction? No / Yes If so, when? _____



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STATEMENT OF FINANCIAL POLICY

As a service to you, this office offers several means of payment for the services and materials which you may require. It is customary to pay the Professional fees at the time of the examination, and to pay for any required materials (spectacles, contact lenses, special visual aids) and /or follow-up care by paying **50% on ordering and the balance on delivery.**

To insure that we understand how to best handle your account, please read this statement CAREFULLY, check the payment plan which you prefer and sign below. If you have any questions, please ask the assistant BEFORE you make your choice.

- Cash or personal check
- Credit card: MasterCard, Visa, or Discover
- Insurance _____

Please note that there will be a **\$25 charge for any returned checks.**

If we are not informed of insurance benefits before services are rendered, we will not be able to file your claim. Loss of benefits may result.

INSURANCE AUTHORIZATION

- I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered.
- I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me.
- I understand that my eye care insurance carrier may pay less than the actual bill for services and **I agree to be responsible for payment of all services rendered to me or my dependents.**
- I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health care practitioners.

PERMISSION TO DILATE

Do you give us permission to dilate your eyes today? You may experience temporary blurred near vision and light sensitivity for several hours; however, your driving should not be impaired. **PLEASE SIGN ONLY ONCE PER VISIT**

Yes No _____ Date _____ Reviewed _____
Patient Signature Dr. Initials

Yes No _____ Date _____ Reviewed _____
Patient Signature Dr. Initials

Yes No _____ Date _____ Reviewed _____
Patient Signature Dr. Initials

Yes No _____ Date _____ Reviewed _____
Patient Signature Dr. Initials

Yes No _____ Date _____ Reviewed _____
Patient Signature Dr. Initials