

WELCOME BACK TO WHITBOURNE EYE CARE

PATIENT INFORMATION

Please fill out this form so that we may update your records. All information will be kept confidential.

Title: Mr./Mrs/Ms./ Dr/other Are you married single divorced other

Name _____ Birthdate _____

Address: _____ Apt# _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email: _____ I prefer to receive calls at: Home Work Cell

HEALTH HISTORY

Have you been diagnosed with a new medical condition since your last visit? Yes No

If yes, please explain _____

List any medications or supplements you are currently taking _____

Do you wear contacts Yes No Do you want to be fit for contacts today? Yes No

Would you like more information about Laser Vision Correction Yes No

INSURANCE INFORMATION

Vision Insurance: _____ Member ID _____

Name of Medical insurance _____

Are you the primary on your insurance? Yes No If no please answer the following:

Name of insured _____ Member ID _____

Birthdate of insured _____ Social Security of insured _____

Employer of insured: _____

RESPONSIBLE PARTY: Self Yes No If no

Name of person responsible for bill _____ **Relationship** _____

AUTHORIZATION

I authorize the eye doctor to release any information including the diagnosis and records of treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature or Signature of parent/guardian

Date

WHITBOURNE EYE CARE

Visual Field Testing

A visual field test is used to determine the functioning of the optic nerve and retina (lining of eye) by testing the peripheral vision (side vision) and is an important part of your comprehensive eye exam.

The **screening** visual field test is a quick, computerized test which can be used to detect disease such as

- Strokes in the eye
- Glaucoma
- Neurological disease/headaches
- Unexplained vision loss
- Vascular disease
- Retinal disease
- Brain tumors

It is highly recommended for all patients.

The fee for this test is \$15.00 and is not covered by your insurance.

- I would like to have the screening test done and agree to pay the fee of \$15
- I would not like to have the test done at this time

signature or signature of parent/guardian

Date

Many times a more detailed version of the test is required. This picks up more subtle changes in the eye and optic nerve therefore giving the doctor valuable information about the health of your eyes. You will be informed if this is necessary.