Patient ID______________ Time in:___________Initials_____________

Welcome to Lake Ridge Vision Source!

Patient's Name: ____________________________ ☐ F ☐ M Appt with: **Dr. Conness** / **Dr. Jablonski** / **Dr.**___________

Date of birth: ______________________________Age:______ Date: ____

New Pt or Last Exam: ____________________________ Reason for Visit: ___________________________________

Race: African American, Caucasian, Latino/Hispanic Email:____

Asian, Other___________________________ Communication preference: Email, Phone Call, Text

Who Can We Thank for Referring You?: _________________________________

Vision and Medical Insurance information:

Primary Medical Ins:__________________________ Secondary Medical Ins:____________________________

Policy Holder Full Name: _______________________ Secondary Policy Holder: _________________________

Policy holder DOB:____________________________ Secondary Policy Holder DOB:____________________

Vision Ins.:__________________ _ Policy Holder Name:____________________________ SSN_________________

Please answer the following question according to how you see with your glasses or contact lenses (if applicable)

Do you have difficulty?

☐Seeing clearly at a distance?
☐ Focusing at a close range?
☐Watching TV? ☐ Reading?
☐ Night Vision?
☐ Computer Range?

Family History:

☐ Glaucoma ☐ Macular Degen.
☐ Cataracts ☐ Keratoconus
☐ Hypertension ☐ Cholesterol
☐ Diabetes ☐ Retina Detachment

Do you currently experience?

☐ Blurry Vision ☐ Burning ☐ Eye Pain
☐ Tearing ☐ Headaches ☐ Double Vision
☐ Flash of light ☐ Dry Eyes ☐ Itchiness
☐ Loss of Vision ☐ Discharge ☐ Eye Fatigue
☐ Foreign body sensation ☐ Sunlight sensitivity
☐ Floater/Spots if so, how long? ________________
If checked any above, please explain:
____

Medical History:

Do you have any medical Problems? NO___ YES___ If yes please list
(i.e. Diabetes, Cholesterol, Hypertension, Thyroid Disease, Glaucoma, Macular Degeneartion, Amblyopia {Lazy Eye} Other:)
If diabetic please provide your latest A1C level ________________

____

____

Do you currently wear?

☐ Glasses? ☐ Reading glasses?
☐ Prescription sunglasses?
☐ Contact lenses? ☐ Unaided

Are you interested in trying contact lenses?
☐ No ☐ Yes ☐ maybe

Do you take any medications?NO____YES___ If yes please list **All** medicines/Supplements

____

____

Are you interested in Lasik?
☐ No ☐ Yes ☐ Maybe
Have you had Lasik, if so when/where?
____

Please list any allergies including drug allergies:

____

Please list any/all eye trauma and/or eye surgery:

____

Social History:

Do you use tobacco products? ☐No ☐ Yes ☐ Quit
if quit how long ago? ______________________

OFFICE USE ONLY

Prescreener:__________ EW Tech:_________

Blood Pressure:________/_________Pulse ______

☐**Comp. Exam** ☐ **Refraction** ☐**CL Exam** ☐ **Medical Exam**

Glasses: NONE/ SV/ Bifocal / PAL

Contacts: Order trials/ Disp'd trials/ Annual Supply

Today/RTO________ days/weeks/months: OK TO DISP

CL CL@DISP OCT VF VEP ERG DIL IOP OV/FU

DX Code: ________________________________

☐ Optos ☐ Dilation Drops ☐ None

Dr. Notes:

Dilation

****Read and check off the option you prefer****

Dilating ones pupils on a yearly basis is a very important part of your preventative eye care. By performing a method of dilation, the doctor can get a much better view of your retina, optic nerve and vessels in the back of the eye to make sure there are no signs of damage or disease.

Dilation Drops: The dilation drops are included in the cost of your exam. In summary, the doctor must put eye drops into your eyes and wait roughly 10-15 minutes **before** seeing you again while the drops take effect (*side effects may occur) Once your pupils are fully dilated, you will go back into an exam room so the doctor may look into your eyes and check the overall eye health. ***Circumstance where dilation may be recommended: flashes, floaters, diabetes, and cataract surgery.**

OptoMap Retinal Imaging: The OptoMap Retinal Photo is a quick and efficient way of allowing your doctor to view the majority of your retina without using drops or having to wait an extended period of time. A thorough screening of the retina is recommended and can lead to early detection of common disease such as **Glaucoma, Diabetes, High blood pressure, Macular degeneration, bleeding in the retina and even Cancer.** The OptoMap is a great asset in the Optometry field as it allows the doctors to keep a permanent digital photo of your eyes year to year as comparison to any changes or variations that may occur. It also provides an in-depth digital image to discuss and answer questions about your eye health during your examination. The cost for this service is **$39.00.**

Dilation Drops *vs.* OptoMap Retinal Imaging

Dilation Drops

1. Blurred near vision for 2-4 hours or more
2. Light sensitivity for 2-4 hours or more
3. Longer overall time for exam while drops take effect
4. No permanent record of retina

OptoMap Retinal Imaging

1. NO Drops required
2. NO light sensitivity/No Blurry Vision
3. Photo takes less than 2 minutes to take
4. Permanent digital image of retina year to year

*With the Dilation Drops, possible side effects may occur. These side effects may include nausea, drowsiness, sensitivity to light, headaches, and lightheadedness (possibly fainting). While dilated, you will not be able to see clearly up-close for reading and computer use for approximately 3-5 hours, and in some cases longer. Those that opt for Dilation Drops will need to exercise caution while driving or operating machinery as vision will be impaired.

SIGNATURE REQUIRED

After reading the above**, please select one**:

_______ I opt to have the **Dilation Drops** and will hold the doctor harmless of any side effects that may occur.

_______ I opt to have the **OptoMap Retinal Imaging** today for the additional **$39.00 charge***.

***If you and a family member both decide to get the OptoMap during your visit on the *same day*, the additional OptoMap is only $20.00 for the other family member(s).**
(Must be same day No Exceptions)

NO INSURANCE WILL COVER THE OPTOMAP

_______ I opt out of both dilation options today.

____ **Patient/Guardian Signature**

Richard Jablonski, OD, Diane Conness, OD
Alicia Kim, OD

Routine vs. Medical Eye Exams

Your vision and the health of your eyes are very important. Eye disease can occur without any symptoms at all, and because of this Lake Ridge Vision Source recommends regularly scheduled eye exams for **ALL** of our patients.

Healthy eyes require a Routine Vision Exam (Annual preventive Exam) every year. This exam will screen for eye disease and provide measurements for glasses and/or contact lenses.

Lake Ridge Vision Source is contracted with only certain vision plans for a Routine Eye Exam. Routine eye exams are defined as a "regular check-up" for patients in need of glasses/contacts. If the chief complaint or primary reason for today's visit is, **dry eyes, diabetes, floaters, cataracts, burning, or itching of the eye, (etc)** may result in a MEDICAL diagnosis

Today you are here for: (Please initial ONE choice)

________ Routine/Annual Preventative Eye Exam

Reason for a Routine/Annual Preventive Eye Exam

- Myopia (Nearsighted) • Presbyopia(Bifocal age)
- Hyperopia (farsighted) • Astigmatism

________ Medical Eye Exam (Please provide PCP information to help us better coordinate your care)

- Exam will be billed to medical insurance
- My portion is my specialist copay and $55 refraction fee.

Reasons for a Medical Eye Exam

- Diabetes ▪ Dry Eyes ▪ Sudden Loss of Vision
- Glaucoma ▪ Iritis ▪Floaters/flashes of light
- Cataracts ▪ Macular Degeneration ▪Painful Eye

Refraction Policy:

Only Initial if having a MEDICAL eye exam, self-pay, or have Medicare as primary Insurance

______**1.** All medical insurance plans, including MEDICARE, do not cover the refraction fee. If your examination includes a refraction, and your insurance does not cover this, there will be a **$55.00** charge.

______**2.** **Refraction** is the measurement of the lens power necessary to prescribe or change your glasses and/or other corrective lenses. A contact prescription CANNOT be given without a current glasses prescription. Refraction may also be done for diagnostic purposes

Please Turn Over

Richard Jablonski, OD, Diane Conness, OD
Alicia Kim, OD

Please Provide your Primary Care Physician's Information to help us better coordinate your care:

Dr. Name: ____________________________Office Name & Number: ______________________________

Please Provide your preferred pharmacy so the office can properly send prescriptions.

Name:____________________________________ Location: ________________________

Phone Number: ______________________

HIPAA Agreement (form can be found at front desk)

"I have read the terms and conditions of the HIPAA consent form, and.."

I Agree □ **I DO NOT Agree** □

Financial Agreement

- Lake Ridge does not bill in office, we outsource to an optometry billing company. Please provide the front desk **ALL COPIES** of medical and vision insurance cards. Our billing company will bill to all primary and secondary insurance if necessary
  - **There is a $35 reprocessing fee if the correct insurance is not given at the time of your appointment.**
- Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is the patients responsibility to pay any deductible, co-insurance, and/or and other balances** not paid by their insurance.
  - If your account is overdue, you will be responsible for any collection fees and costs.
  - **There is a late penalty fee of $25 dollars for ANY account overdue of 90 days.**
- Lake Ridge Vision source is not required to obtain any referrals required by your insurance. If you require a referral and do not obtain one for your appointment, you will be held liable for any charges.
- All co-pays, balances, orders of eye glasses, and/or orders of contacts must be paid in full at the end of your visit. We accept personal check, cash, or credit/debit card.

  NO GLASSES OR CONTACT ORDERS WILL BE PLACED UNTIL ALL PAYMENTS ARE MADE.
- Lake Ridge Vision Source cannot release any patient information without the consent of that patient. If you would like the office to release any information to another provider or person, please ask the front desk for a Records Release From. **If a patient is over 18 and would like a parent or other family member to have access to their records, please ask the front desk for a Release of Information form.**
- We request that you keep scheduled appointments and arrive at the appointment time. If you are unable to keep your appointment, please give at least a 24-hour notice. Same day cancellations or a no show to the appointment will result in a **$50 fee per patient.**

All the staff at Lake Ridge Vision Source appreciates your confidence in allowing us to participate in your eye care. Your signature indicates that you have read, understand, and agree to all the policies and procedures of our Practice.

Please Sign: _______________________________

Print Name: _______________________________ Date: ___________