Welcome and thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, do not hesitate to ask. Please check with the front desk to confirm if we are providers for your insurance plan. We accept all major credit cards, and Care Credit. Co-Payments are expected at the time of service.

Dr. Mr. Mrs. Ms. Patient: (full legal name)_____________________________________ Preferred name:______________________

Mailing Address:____City:__________________State:___________Zip:_______________

Phone#: (______)______________________ Cell#: (______)______________________ Texting OK? Y / N

Email:____________________________________ Marital Status: Single Married Divorced Widowed

Date Of Birth:_____/_____/_____ Sex: Male Female Social Security #: _________-_________-_________

Patient Employer/School:____ Occupation:___________________________________

Medical Insurance Provider:______________________________________ Vision Plan:____________________________________

Primary Policyholder:_________________________________ Relationship to Patient:_____________________________________

SSN of Responsible Party:_______-_______-_______ DOB of Responsible Party:______/______/________

Emergency Contact & Phone:_____________________________________ Relationship to Patient:_____________________________

Family/Primary Care Physician:______________________________ Phone#: (____)___________________

Your Pharmacy: ____ Phone#: (____)___________________

Whom should we thank for referring you to our practice?

Internet Drove by Yellow Pages Insurance Company Family/Friend:________________________________

Referring Physician:_______________________________________ Other:_________________________________

Reason(s) for today's visit: (Please circle all that apply)

Wellness Vision: Routine eye exam Glasses/Refraction Contact Lenses

Medical Eye Care: Diabetes Cataracts Glaucoma Dry Eye Red Eye/Infection Injury

Macular Degeneration Plaquenil Screening Other:____

Pupil Dilation: The use of eye drops to widen your pupils allows the doctor to view of the entire retina as part of your ocular health assessment. Eye drops may also be necessary to assist in the determination of the eye glass prescription, especially in children. Dilation drops widen the pupils in approximately 15 minutes, and the examination takes about 5 minutes. The drops wear off in 2-4 hours in most people but can take up to 12 hours. Common side effects are increased light sensitivity (complimentary sunglasses provided), glare and reduced near focusing ability. Distance vision is not significantly affected in most people; however caution should be used when driving. Please inform staff if you are uncomfortable performing normal activities and need to defer dilation.

I agree that the information supplied is accurate to the best of my knowledge. I authorize Dr. Cara Patterson Robison, North Georgia Eye Care at my request, to file and release to any insurance company I may choose, any information necessary to process a claim for benefits. I understand that verification of my insurance benefits via phone/internet is not a guarantee of payment. I understand I am responsible for any unpaid balances not paid by my insurance. Any outstanding balances over 90 days past due will be turned over to the Collection Services of Athens for further collection procedures. A copy of this may be used in place of the original.

SIGNATURE:____ DATE:_____/_____/_______

NAME ____ **DATE** ______________________
DATE OF LAST PHYSICAL ______/_______/_______ DATE OF LAST EYE EXAM ______/_______/_______
LIST **ANY MEDICATIONS** YOU CURRENTLY TAKE (RX OR OVER-THE-COUNTER) ______________________
____
Do you have **ALLERGIES** to any medications? YES NO
If YES, list the medications: ____
List all major illnesses (diabetes, high blood pressure, heart attack, stroke, etc) or injuries (concussions):
____
List any major surgeries: ____
Do you currently have any problems in the following areas? **If YES, please give details:**

REGION/CIRCLE ALL THAT APPLY	YES	NO	DETAILS
EYES (eye pain, tearing, redness, discharge, glare, headache, change in vision, floaters, ocular trauma, double vision, difficulty driving, flashes of light, eyelid swelling, eye strain, loss of vision)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss/gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuff nose, earache, cough, dry mouth)			
CARDIOVASCULAR (high BP, racing pulse)			
RESPIRATORY (congestion, wheezing, short of breath)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcer)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice)			
FEMALES: Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis)			
SKIN (acne, warts, growths, rash)			
NEUROLOGICAL (numbness, headache, seizures, paralysis)			
ENDOCRINE (diabetes, hypothyroid)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, HIV, Hepatitis C)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling, Cousin)
Has any member of you family had these diseases? (Circle all that apply) YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other inheritable disease: ________________________________

SOCIAL HISTORY
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO
Do you drink alcohol? YES NO IF YES, how much? _____________________________
Do you smoke? YES NO IF YES, how much? ________________ How many years? ______

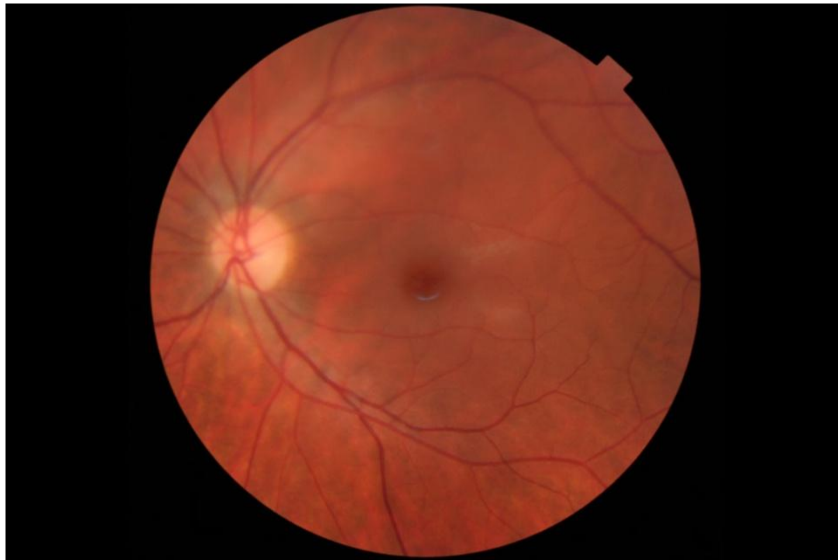
Signature ______________________________________ **Date** ___________________

iWellness Exam

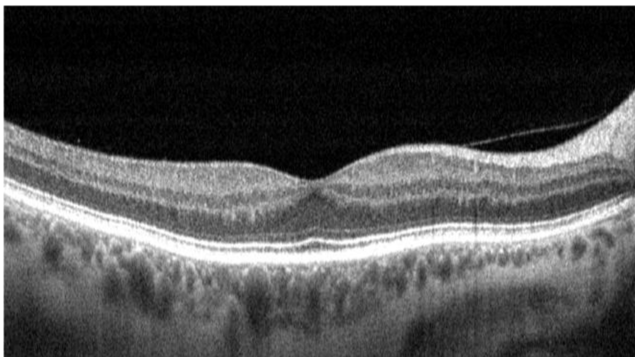
Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam™ SD- OCT retinal scan and Digital retinal imaging as part of your eye exam today.

Our technician will perform these two tests before you go into the exam room and

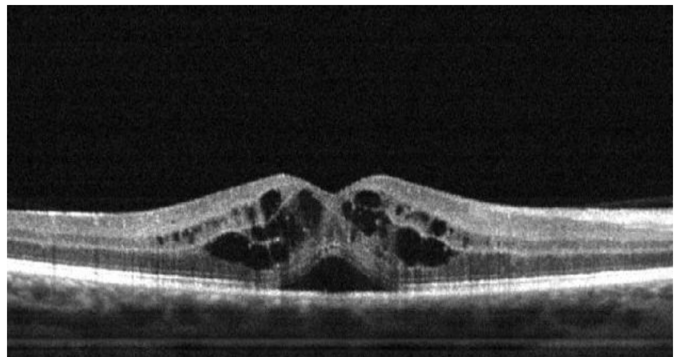
Dr. Robison will review these with you during your examination today. These two tests will become a part of your permanent patient record. The $35 charge is not covered by your medical or vision insurance . This cost will be added into the price of your visit today.



Normal retinal photograph



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam often invisible to photos and ophthalmoscopy

___ Yes, I would like the iWellness performed today

___ No, I do not wish to have the iWellness performed today

___ I would like to discuss the iWellness further with Dr. Robison

Signature____ Date:____/____/_____

North Georgia Eye Care Cancellation / No-Show Policy

Here at North Georgia Eye Care we strive to provide the highest quality service possible to all of our patients. We are always happy to try to schedule appointments to accommodate your busy schedule. However, if you are unable to keep an appointment, we ask that you give us a 24 hour notice. Making your appointment as scheduled is very important, not just for us, but for you as well. Appointment times are in demand and a missed appointment is not only lost revenue for us, but an appointment time that someone else could have used.

If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 24 hours in advance. If you cancel your appointment without a 24 hour notice or if you fail to show up for your appointment time, a $25 charge will be applied to you account. North Georgia Eye Care also reserves the right to cease rescheduling appointments due to habitual no-shows or cancellations.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy allows us to better schedule our patient's appointments at times that are convenient for them and is fair for everyone.

Thank you for your consideration and understanding on this matter and we look forward to your appointment time with us.

I have read the above and understand the cancellation / no-show policy of North Georgia Eye Care.

______________________________________ _______________

Patient/Guardian Signature **Date**