Date _____

EINHORN
EYECARE CENTER

## Patient Information (please print clearly):

Name _____ E-mail _____

Address _____ City _____ State _____ Zip Code _____

Home # _____ Cellular # _____

DOB _____ Social Security Number _____

Occupation _____ Employer _____

Pharmacy _____ Pharmacy phone number _____

Vision Insurance _____ ID# _____ Primary Member _____

Medical Insurance _____ ID# _____ Primary Member _____

## Ocular History

Y N Distance blur
Y N Near blur
Y N Computer blur
Y N Do you wear sunglasses?
Y N Strabismus (eye turn)
Y N Burning
Y N Itchy
Y N Redness
Y N Tearing
Y N Dryness
Y N Glaucoma
Y N Macular Degeneration
Y N Cataracts
Y N Amblyopia (lazy eye)
Y N Eye surgeries
Y N Family history Glaucoma
Y N Family history Mac. Degen.

Other _____

## Medical History

**Allergies** _____
**Cardiovascular**
Y N Elevated Cholesterol
Y N Hypertension
**Constitutional**
Y N Fever/Nausea
**Endocrine**
Y N Diabetes
Y N Thyroid Disease
**Gastrointestinal**
Y N Crohn's Disease
**Genitourinary**
Y N Uterine/Prostate Cancer
Y N Syphilis
**Hematologic/Lymphatic**
Y N Anemia
Y N Coagulation disorders

**Immunologic**
Y N HIV/AIDS
**Integumentary (skin)**
Y N Acne Rosacea
Y N Lupus
**Musculoskeletal**
Y N Arthritis
**Neurological**
Y N Headaches
**Psychological**
Y N Depression
**Pregnant or Nursing**
Y N
**Respiratory**
Y N Asthma
Y N COPD
Y N Lung Cancer

Other _____ _____

List all current eye medication(s) _____

List all other current medication(s) _____

_____

Hobbies _____

Are you interested in new glasses? Y N

Interested in Laser Vision Correction? Y N

Name of family doctor _____ Phone _____ Date of last physical _____

HIPAA: I acknowledge that I have read the copy of the Notice of Privacy Practices.

Signature _____

Financial policy/Insurance:

- Insurance authorizations are not a guarantee of payment from your insurance company. If your insurance does not cover any services or materials, you will be billed and held responsible for any balance.

Eyewear Policy/Warranties:

- If there are any issues with your new glasses, you may return for a prescription re-check at no charge within 60 days of the exam date. Necessary changes will be made at no charge. After 60 days, re-check visits will be at a charge of $50 and new lenses will be charged at the usual fees.
- We do not take any responsibility in the accuracy or quality of materials made outside this office. We recommend you reach an agreement with your eyeglass dispenser before you place your order elsewhere. Most reputable optical dispensaries allow for a doctor's prescription change at no charge, but it is up to the patient to inquire about such policies.
- Since glasses are custom orders, there is a 25% cancellation fee on the lenses processed.
- Non prescription sunglasses are not refundable.
- Lenses purchased with a glare free lens or transitions lenses have a one time scratch warranty during the first year.
- All frames purchased at our office have a one year warranty (shipping charges apply). If a frame becomes discontinued during your warranty period, store credit will be given towards the purchase of another frame.
- We are not responsible for any breakage or lost item that may occur when using your own frame either at our lab or at your insurance's lab. _____
- For progressive lenses, there is a two month non adapt time period from the date of purchase, during which the lenses can be exchanged towards the order of another lens (single vision/bifocal). Price difference is non-refundable.
- We are not responsible for glasses or contact lenses that are not picked up within 60 days. Payments or deposits are non-refundable.

Eye Exam and Contact Lens Policy:

- Contact lens evaluations involve additional procedures and therefore require an added fee which is not covered by most insurances. Contact lens follow ups are included up to 2 months from original evaluation.
- Eye exam and contact lens evaluation fees are non-refundable.

I have read and understand the policies above: Signature:  _____

**For office use only:**

Wellness scan? Yes or No IOP: _____

1) OLD Glasses: ADD: _____ DVO/NVO/BF/comp SV/PAL/Occ PAL

2) OLD Glasses: ADD: _____ DVO/NVO/BF/comp SV/PAL/Occ PAL

Interested in Glasses / Contact Lenses /Both ?