PATIENT HISTORY FORM:

Name:____

Address:____

City: ________________________State: _____________ Zip Code:_______________

Birth Date:____/____/________

Email Address:____

Employer(or school):____

Phone number: Work:____

Cell:____

Home:____

Social Security Number: ________-________-__________

Marital Status: Single Married

Medical History:
Do you have any allergies to medication: ____YES_____NO
If yes please explain:

____

Please list any medical conditions you have:

____

List any current medications (please include birth control, aspirin, over-the-counter meds and home remedies):

____

Check any of the following you have had: __Crossed Eyes __Lazy Eye
__Cataracts __Eye Injury __Retinal Disease __Reading Difficulty __Glaucoma
Are you pregnant or nursing? __YES____NO
Do you wear glasses? __YES____NO
If yes, how old is your current pair?________________________
Do you wear contact lenses __YES ____NO
If yes, how old is you current pair?________________________
Is the current pair still comfortable? __YES ____NO
Have you had refractive surgery? __YES ____NO
Are you outdoors all or part time? __YES ____NO
Are you sensitive to sunlight? __YES ____NO
Do you own any sunglasses? __YES ____NO
Do you want your eyes dilated today? __YES ____NO
What sports or hobbies do you enjoy:________________________________
Are you a smoker: Y N If yes, how much? ________________________
Do you drink alcohol: Y N If yes, how much? ________________________

Primary Medical Insurance Company:________________________

Subscriber's Name:____

Subscriber's SSN or ID number:________________________________

Subscriber's Date of Birth:_____/______/_________

Vision Insurance:____

Subscriber's Name:____

Subscriber's SSN or ID #:________________________

Subscriber's Date of Birth:______/_______/_________

Vision care plans only cover routine vision exam, materials, and basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases. Medical insurance must be used if you have any eye health problems or systemic health problems that have ocular complications. It may be necessary for us to bill some services to one plan and other services to the other. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract. Please initial ______

VERY IMPORTANT! NEW PATIENTS ONLY

HOW DID YOU HEAR ABOUT US OR WHO MAY WE THANK FOR REFERRING YOU TO OUR

OFFICE?____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Crawford Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Crawford Eye Care's Notice of Privacy Practice and agree to continue my care with Crawford Eye Care under said terms.
- ☐ I was given the opportunity to read Crawford Eye Care's Notice of Privacy Practices and declined but wish to continue my care with Crawford Eye Care under the terms of Crawford Eye Care's privacy policies.
- ☐ I have read or had explained to me Crawford Eye Care's Notice of Privacy Practice and do not wish to continue my care with Crawford Eye Care under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  ____

  ____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____________________________ ______________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

____________________________ __________________
Representative Relationship to Patient

Crawford Eye Care is proud to offer digital retinal photography as part of your eye examinations today. Our doctors check for eye diseases such as macular degeneration and glaucoma in every complete examination. Systemic diseases like diabetes and hypertension can also cause eye problems leading to partial and in some cases complete vision loss. Our doctors do recommend the digital photograph because of the excellent resolutions obtained with the camera. It is a very quick, easy procedure and does not usually require dilation.

A screening digital retinal photograph includes:

1) A 20 degree field of view photo showing the optic nerve head, vessels, macular area, and retina.
2) A baseline photograph that can be used for comparison annually to detect early signs of disease processes.
3) The ability to review your internal ocular health with your doctor.

If you choose to accept the digital retinal photograph, it is not covered by insurances and is an additional fee of $30.

Thank you,
Drs. Adam & Karmen Crawford and Dr. Lauren Eaton

ACCEPT___________ DECLINE________

SIGNATURE____

DATE__________________

CRAWFORD EYE CARE
CONTACT LENS FITTING AGREEMENT

We want to thank you for considering a contact lens fitting with the doctors of Crawford Eye Care. Fitting you will contact lenses places a joint responsibility on the doctor; therefore, you must understand what our contact lens fitting program includes. Please read this over carefully and if you have any questions, please do not hesitate to ask.

Our contact lens patients receive the following materials and services:

- Assessment of visual needs and expectations.
- Evaluation and determination of prescription and eye health in regard to contact lens wear.
- Diagnostic trial lens fitting.
- Dispensing of contact lenses, patient care kit, and instruction in handling, care and maintenance of our contact lenses.
- Follow-up examination to monitor eye health, prescription accuracy, and appropriate fit with a 30-day period.

Below are the categories of fitting fees. Your fees will be determined by the physician. Fees do not include the price of the contact lenses.

Fitting fees are as follows:

Renewal of contact lens fit and power (The re-validates your prescription for one year)	**$40.00**
New fitting for monovision and multifocal contact lenses	**$50.00**(no training) **$95.00**(w/training)
First time contact lens wearer; to include training on proper Techniques and trial contact lenses.	**$75.00**

All fitting fees include two contact lens follow-up examination within 30 days.

Each additional follow-up charge	**$20.00**

Policies:

- Charges for fitting fees are due at time of the fitting evaluation and are non-refundable.
- Many insurance plans do not cover the full cost of contact lens fees. You will be responsible for any uncovered costs incurred by the eye exam, contact lens fitting or contact lenses.
- You are responsible for scheduling and attending follow up visits in order to finalize your prescription.
- Your prescription will not be released and contact lenses will not be ordered for you until your prescription has been finalized by the doctor.
- Contact lens prescriptions expire after one year in the state of Mississippi.

______________________________ ______________

Patient or Guardian Signature **Date**