

**GENERAL INFORMATION**

FULL NAME \_\_\_\_\_ SALUTATION: DR. \_\_\_ MR. \_\_\_ MRS. \_\_\_ MS. \_\_\_ SEX: M \_\_\_ F \_\_\_  
SPOUSE'S NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ EMAIL \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
COMMUNICATION PREFERENCE: EMAIL \_\_\_ POSTAL \_\_\_ TELEPHONE \_\_\_ TEXT \_\_\_  
MAY WE CONTACT YOU ELECTRONICALLY: YES \_\_\_ NO \_\_\_

**MEDICATION LIST:**

**INSURANCE INFORMATION**

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

INSURANCE CO \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ID NUMBER \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_  
INSURED DOB \_\_\_\_\_  
INSUREDS SS# \_\_\_\_\_  
RELATIONSHIP TO INSURED \_\_\_\_\_

INSURANCE CO \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ID NUMBER \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_  
INSURED DOB \_\_\_\_\_  
INSUREDS SS# \_\_\_\_\_  
RELATIONSHIP TO INSURED \_\_\_\_\_

**ATTENTION CURRENT CONTACT LENS PATIENTS**

PER NYS REGULATIONS, YOUR CONTACT LENS PRESCRIPTION WILL BE VALID FOR UP TO 1 YEAR. AFTER 1 YEAR, THE PRESCRIPTION EXPIRES. IF YOU WANT TO CONTINUE TO WEAR CONTACT LENSES, YOU MUST RETURN FOR A CONTACT LENS EVALUATION. THE DOCTOR WILL VERIFY THAT YOUR EYES ARE RESPONDING WELL TO CONTACT LENS WEAR, CHECK THE OCULAR SURFACE FOR ANY DAMAGE AND MAKE SURE THE LENSES ARE STILL FITTING PROPERLY AND THAT YOU HAVE THE CORRECT PRESCRIPTION FOR YOUR EYES. THE DOCTOR WILL NOT RENEW EXPIRED PRESCRIPTIONS WITHOUT FIRST MAKING SURE THAT YOUR EYES ARE HEALTHY ENOUGH TO WEAR LENSES. TO AVOID ANY INCONVENIENCE, MAKE SURE YOUR ANNUAL EXAMINATION IS SCHEDULED ON TIME SO THAT YOU DO NOT RUN OUT OF LENSES BEFORE YOU ARE SEEN. THE ANNUAL RENEWAL OF YOUR CONTACT LENS PRESCRIPTION REQUIRES ADDITIONAL TIME AND TESTING WHICH IS NOT INCLUDED IN THE ROUTINE EXAMINATION, THEREFORE AN ADDITIONAL FEE WILL BE CHARGED. THE ADDITIONAL FEE IS \$49. THIS FEE DOES NOT INCLUDE REFITTING TO A DIFFERENT LENS, OR LENS TYPE. REFITTING FEES WOULD THEN APPLY. IF YOU ARE NEW TO CONTACTS, A NEW FIT FEE WILL BE CHARGED. YOU MAY CHOOSE TO DECLINE THIS EVALUATION. IF YOU ARE COMING IN FOR A YEARLY CONTACT LENS EXAM WITHOUT A ROUTINE EXAM, THE FEE WILL BE \$59.

- \_\_\_\_\_ I WISH TO HAVE THE CONTACT LENS EVALUATION TODAY AND AGREE TO PAY THE FEE OF \$49.
- \_\_\_\_\_ I WISH TO HAVE THE YEARLY CONTACT LENS EXAM WITHOUT A ROUTINE EXAM, AND AGREE TO PAY \$59.
- \_\_\_\_\_ I DECLINE THE CONTACT LENS EVALUATION AND UNDERSTAND THAT I CANNOT BE PROVIDED WITH A PRESCRIPTION FOR CONTACTS, OR RE-ORDER NEW CONTACTS AT THIS TIME.

**OPTOMAP ULTRA WIDE DIGITAL IMAGING**

THE RETINAL IMAGING IS FAST, PAINLESS AND COMFORTABLE. NOTHING TOUCHES YOUR EYE AT TIME. IT IS SUITABLE FOR THE WHOLE FAMILY. TO HAVE THE EXAM, YOU SIMPLY LOOK INTO THE DEVICE ONE EYE AT A TIME AND YOU WILL SEE A FLASH OF LIGHT TO LET YOU KNOW THE IMAGE OF YOUR RETINA HAS BEEN TAKEN. THE CAPTURE TAKES LESS THAN A SECOND. IMAGES ARE AVAILABLE IMMEDIATELY FOR REVIEW. YOU CAN SEE YOUR OWN RETINA. YOU SEE EXACTLY WHAT THE DOCTOR SEES.

**THE BENEFITS OF HAVING A RETINAL IMAGE TAKEN ARE:**

- ❖ EARLY DETECTION FROM VISION IMPAIRMENT OR BLINDNESS
- ❖ EARLY DETECTION OF LIFE-THREATENING DISEASES LIKE CANCER, STROKE AND CARDIOVASCULAR DISEASE

THERE IS AN ADDITIONAL CHARGE OF \$45 FOR THIS PROCEDURE. IF A MEDICAL DIAGNOSIS IS MADE BECAUSE OF THIS PROCEDURE, THEN WE CAN BILL YOUR MEDICAL INSURANCE CARRIER. IN MOST CASES, INSURANCE COMPANIES **WILL NOT** COVER THIS TEST WHEN DONE ROUTINELY.

\_\_\_\_\_ I DO WANT THIS TEST PERFORMED \_\_\_\_\_ I WANT TO SPEAK WITH THE DOCTOR BEFORE THE TEST IS PERFORMED

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_