MAXTON VISION GROUP
COME SEE CLEARLY

**Welcome back!**

Today's Date: _____ Date of last eye exam: _____

Patient Name: _____ Patient's date of birth: _____

Mailing address: □Same □New address: _____

Phone numbers: Cell: _____ Work: _____ extension_____

**Our office uses text messaging to confirm future appointments and to notify patients of their glasses and contact lenses. Standard text-messaging rates may apply with your carrier.**

□ **OK** □ **No**, I would like to opt out of text messaging. Call me instead.

Email address: _____

Reason for today's visit: □Routine vision care □Glasses □Contact lenses □Red eye/Office visit

□ Other: _____

**Insurance: Please present all insurance information prior to your examination.**

Vision insurance: □No change □New plan: _____ID #_____

Medical insurance: □No change □New plan: _____ ID #_____

Primary Cardholder's Name: □Self _____

Relationship to patient: □Spouse/significant other □Parent/Guardian

Primary Cardholder's SSN: _____ Primary cardholder's DOB: _____

Authorization: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company(s) and assign directly to Julie K. Ly, OD & Associates (dba Maxton Vision Group) all insurance benefits, if any, otherwise payable to me for services rendered and/or eyewear purchases. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Today's date: _____

**Eye History** (Please check all that applies, currently and in the past)

□Eye pain/soreness □Fatigue/Tired eyes □Dry/gritty feeling □Redness □Burning/Stinging □Itching □Watery eyes
□Blurry vision □Double vision □Floating spots □Flashing lights □Eye infection □Eye injury □Cataracts □Glaucoma
□Macular degeneration □Retinal detachment □Keratoconus □Bell's Palsy
□Eye surgery: _____ □Eye drops currently:_____

**Personal Health History:** Please list any health changes or medication changes from the previous visit.

□No changes in medical history or medications. □Yes, there have been some changes: _____

Female patients are you pregnant? □ No □ Yes, # of months: _____

Name:

**Retinal Evaluation**

A retinal exam is required. This checks for any holes, tears, retinal detachment, macular degeneration, bleeding, glaucoma and other diseases that can impact your vision, including Hypertension, Diabetes, High Cholesterol and Cancer.

Drops will be used to dilate (or open) the pupils to allow a thorough evaluation of the health of the retina and other structures in the back of the eye. Your eyes will become blurry for 3-4 hours, and you will be provided with some temporary sunshades to help with light sensitivity.

□ Take retinal photos instead. There are no side effects with this option, and the photos become a valuable part of your chart for comparison of progression of diseases or changes to the back of the eyes. This comes highly recommended by your eyecare team as a screening tool. **The fee is $39.**

Signature: _____ Date:_____

**Visual field screening (automated machine):**

Visual field screening can detect areas of missing vision in both the central and peripheral vision. The test can show early symptoms of various medical conditions such as glaucoma, stroke, brain tumors, macular degeneration, diabetes, high blood pressure, and other neurological problems. It can also help monitor changes caused by some medications. If the screening is abnormal, the doctor will request for a more detailed visual field to map out the exact areas of vision loss. **The fee is $29** □ yes □ no

Signature: _____ Date: _____

□ **For a reduced fee of $60, I would like both Retinal Photos and a Visual Field screening for a more detailed exam.**

Signature: _____ Date: _____

**Federal Health Insurance Portability & Accountability Act (HIPAA)**

I acknowledge that I have received and/or reviewed a copy of the HIPAA Privacy Practices (see bottom form).

Signature: _____ Date:_____