Advanced Technology Offered by Eugene Vision Care

Visual Field Testing

Visual field testing is a tool used by your eye care provider to detect defects in your visual field. These defects can be caused by a number of medical conditions that can affect your eyes or the pathway from your eyes to your brain. These conditions include but are not limited to:

- ➔ **Diabetes**
- ➔ **High Blood Pressure**
- ➔ **Stroke**
- ➔ **Glaucoma**

This visual field screening is **NOT** covered by insurance for routine vision exams but is highly recommended by your eye care provider.

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iWellness Scan

The iWellness scan is an easy to ready report that displays the health of our retina as compared to a database of normal eyes. It is a 3D image of your retina and can detect the early onset of a variety of eye conditions and eye disease including but not limited to:

- ➔ **Macular Degeneration**
- ➔ **Glaucoma**
- ➔ **Diabetic Retinopathy**

This iWellness scan is **NOT** covered by insurance for routine vision exams but is highly recommended by your eye care provider.

Please indicate if you would like either of these tests or both by checking one box below.

❒ Yes, I would like the **visual field screening** completed and agree to pay the associated fee.
Fee: **$25.00**

❒ Yes, I would like the **iWellness scan** completed and agree to pay the associated fee.
Fee: **$47.00**

❒ Yes, I would like **BOTH** the visual field screening and iWellness scan test completed and agree to pay the associated fee. **Fee: $58.00**

❒ I do **NOT** want to do the visual field test screening or iWellness scan at this visit.

WELCOME TO EUGENE VISION CARE

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE INFORMATION TO FRONT DESK

Date _____

Patient's Name: _____

DOB _____/_____/_____

Address _____

City _____ State_____ Zip_____

Phone _____

Email _____

Last 4 digits of SSN#_____

Employer_____

Occupation _____

Single/Married/Widowed/Minor

Parent Name if Minor _____

Last PCP Visit _____/_____/_____

Primary Doctor _____

Last Eye Exam_____/_____/_____

Previous Eye Dr. _____

Do you wear glasses? ❒Yes ❒No

Do you wear contact lenses? ❒Yes ❒No

Are you interested in contact lenses? ❒Yes ❒No

Are you interested in refractive surgery? ❒Yes ❒No

Do you perform fine or close-up work? ❒Yes ❒No

Do you experience flashes of light? ❒Yes ❒No

If yes when?_____

Do you have double vision? ❒Yes ❒No

If yes when? _____

What is the main reason for your visit today? _____

Review of Systems - Please mark "yes" or "no" to indicate if you have had any of the following:

Constitutional	**YES**	**NO**
Developmental Delay	❒	❒
Cancer	❒	❒
Fatigue Syndrome	❒	❒
Cardiovascular		
Hypertension	❒	❒
Stroke/CVA	❒	❒
Heart Disease	❒	❒
Vascular Disease	❒	❒
Congestive Heart Failure	❒	❒
Ears/Nose/Throat		
Hearing Loss	❒	❒
Sinusitis	❒	❒
Dry Mouth	❒	❒
Chronic Cough	❒	❒
Respiratory		
Asthma	❒	❒
Bronchitis	❒	❒
Emphysema	❒	❒
COPD	❒	❒
Sleep Apnea	❒	❒

Gastrointestinal	**YES**	**NO**
Chron's Disease	❒	❒
Colitis	❒	❒
Ulcer	❒	❒
Acid Reflux	❒	❒
Celiac Disease	❒	❒
Genito-Urinary		
Prostate	❒	❒
Kidney	❒	❒
Pregnant	❒	❒
Herpes	❒	❒
Musculoskeletal		
Arthritis	❒	❒
Osteoarthritis	❒	❒
Fibromyalgia	❒	❒
Ankylosing Spondylitis	❒	❒
Integumentary (skin)		
Excema	❒	❒
Rosacea	❒	❒
Psoriasis	❒	❒
Cold Sores	❒	❒
Shingles	❒	❒

Neurological	**YES**	**NO**
Multiple Sclerosis	❒	❒
Epilepsy	❒	❒
Cerebral Palsy	❒	❒
Tumor	❒	❒
Migraine	❒	❒
Psychiatric		
Anxiety/Depression	❒	❒
Endocrine		
Type 2 Diabetes	❒	❒
Type 1 Diabetes	❒	❒
Thyroid Dysfunction	❒	❒
Hormonal Dysfunction	❒	❒
Lymphatic-Hematolog		
Anemia	❒	❒
Bleeding Problems	❒	❒
Immunologic		
Grave's Disease	❒	❒
Lupus	❒	❒
Sjogren's Syndrome	❒	❒
Organ Transplant	❒	❒
HIV	❒	❒

Office Use: NP EP IN NI EG CL OV

Please complete the back side of the form.

Ocular History

(mark yes or no)

Age-related macular degeneration	❒ Yes	❒ No	Injury to the eye region	❒ Yes	❒ No
Amblyopia (lazy eye)	❒ Yes	❒ No	Keratoconus	❒ Yes	❒ No
Blindness-one eye	❒ Yes	❒ No	Retinopathy	❒ Yes	❒ No
Blindness-both eyes	❒ Yes	❒ No	Strabismus (crossed eyes)	❒ Yes	❒ No
Cataracts	❒ Yes	❒ No	Tear film insufficiency (dry eyes)	❒ Yes	❒ No
Glaucoma	❒ Yes	❒ No	Other: _____		
History of refractive surgery	❒ Yes	❒ No	_____		

Family Health History ❒ Unknown (mark yes or no-If yes circle which family member. F=father M=mother B=brother S=sister A=aunt U=uncle G=grandparent)

Amblyopia (lazy eye)	❒ Yes	❒ No	F M B S A U G	Strabismus (crossed eyes)	❒ Yes ❒ No F M B S A U G
Vision Impairment	❒ Yes	❒ No	F M B S A U G	Arthritis	❒ Yes ❒ No F M B S A U G
Cataract	❒ Yes	❒ No	F M B S A U G	Cancer	❒ Yes ❒ No F M B S A U G
Macular Degeneration	❒ Yes	❒ No	F M B S A U G	Diabetes Mellitus	❒ Yes ❒ No F M B S A U G
Glaucoma	❒ Yes	❒ No	F M B S A U G	Hypertension	❒ Yes ❒ No F M B S A U G
Retinal Disorder	❒ Yes	❒ No	F M B S A U G	Cardiovascular Disease	❒ Yes ❒ No F M B S A U G
				Stroke	❒ Yes ❒ No F M B S A U G

Social History (check one for each question)

Are you a drug user? ❒ Yes ❒ No

Are you a: ❒ Non Drinker ❒ Heavy Drinker
❒ Social Drinker

Tobacco Use/Smoking History

❒ Cigarette smoker ❒ Light tobacco smoker
❒ Cannabis smoker ❒ Former smoker
❒ Vape ❒ NEVER smoker
❒ Smokeless tobacco

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

_____
_____
_____
_____
_____
_____
_____

❒ No Medications

Allergies

List any allergies you may have and reaction.

_____
_____
_____
_____
_____
_____
_____

❒ No Medication Allergies ❒ No Other Allergies

_____ Date: _____/_____/_____

Patient/Guardian Signature

EUGENE
VISIONCARE

General Billing Information

All out of pocket costs are due at the time of service. We accept all major credit cards for your convenience. On occasion, coinsurance and deductibles may only be determined after your insurance is billed. This may leave a balance on your account. If you have a balance, you will be sent a statement at the beginning of each month. Failure to show for an appointment will result in a $25.00 charge. Please direct all billing inquiries to 541.687.8666.

Private/Group Health Insurance

Please remember that insurance estimates are based on information provided by your insurance company. Eligibility and benefits quoted by insurance are an estimate only and not a guarantee of payment. As a courtesy, your primary insurance will be billed. You are ultimately responsible for services that are not covered by your insurance.

Medicare

Eugene Vision Care does accept and bill Medicare. If you have a secondary plan or a supplement, please provide it at the time of service. You are responsible for all deductibles and coinsurance left by Medicare. You may be asked to sign an Advanced Beneficiary Notice for any care not covered by Medicare.

Notice of Privacy Practices

I understand that Eugene Vision Care will use and disclose health information about me, to make decisions about my healthcare, billing my insurance and manage along with other health care providers for my care and treatment. I understand that I have the right to ask that some or all of my health information not be used or disclosed.

My signature below acknowledges that I have been provided or offered a copy of the Notice of Privacy Practices and have reviewed the office financial and billing policies.

_____ _____

Signature of Patient or Guardian Date