



Welcome back and thank you for choosing us for your eye care needs. We are delighted to have you return and appreciate the confidence you have placed in us. Please take a moment to update the following information for ANY CHANGES to your personal or medical history. If you have any questions, do not hesitate to ask. Please check with the front desk to confirm if we are providers for your insurance plan. We accept all major credit cards, and Care Credit. Co-Payments are expected at the time of service.

Dr. Mr. Mrs. Ms. Patient: (full legal name) _____

Preferred name: _____ DOB: ____/____/____

Mailing Address : _____ City: _____ State: _____ Zip: _____

Phone#: (____) _____ Cell#: (____) _____ Texting OK? Y /N

Email: _____ Marital Status: Single / Married / Divorced / Legally Separated / Widowed

Patient Employer/School: _____ Occupation: _____

Medical Insurance Provider: _____ Vision Plan: _____

Primary Policyholder: _____ SSN of Responsible Party: _____ - _____ - _____

DOB of Responsible Party ____/____/____ Relationship to Patient: _____

Emergency Contact & Phone: _____ Relationship to Patient: _____

Family/Primary Care Physician: _____ Phone#: (____) _____

Your Pharmacy: _____ Phone#: (____) _____

Reason(s) for today's visit: (Please circle all that apply)

Wellness Vision: Routine eye exam Glasses/Refraction Contact Lenses

Medical Eye Care: Diabetes / Cataracts / Glaucoma / Dry Eye / Red Eye/Infection / Injury

Macular Degeneration / Plaquenil Screening / Other: _____

Do you have ALLERGIES to any medications? YES NO

If YES, list the medications: _____

LIST ANY MEDICATIONS YOU CURRENTLY TAKE (RX OR OVER-THE-COUNTER) _____

List all major illnesses (diabetes, high blood pressure, heart attack, stroke, etc) or injuries (concussions):

List any major surgeries: _____

Pupil Dilation: The use of eye drops to widen your pupils allows the doctor to view of the entire retina as part of your ocular health assessment. Eye drops may also be necessary to assist in the determination of the eye glass prescription, especially in children. Dilation drops widen the pupils in approximately 15 minutes, and the examination takes about 5 minutes. The drops wear off in 2-4 hours in most people but can take up to 12 hours. Common side effects are increased light sensitivity (complimentary sunglasses provided), glare and reduced near focusing ability. Distance vision is not significantly affected in most people; however caution should be used when driving. Please inform staff if you are uncomfortable performing normal activities and need to defer dilation.

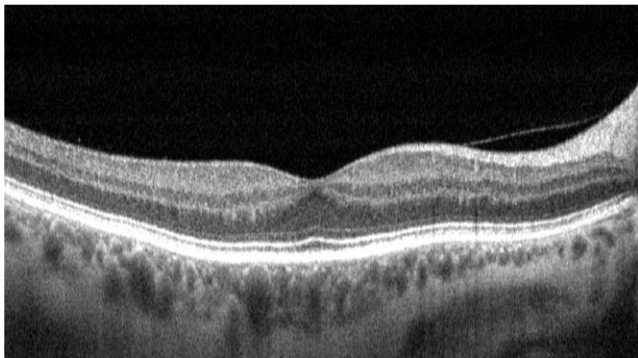
I agree that the information supplied is accurate to the best of my knowledge. I authorize Dr. Cara Patterson Robison, North Georgia Eye Care at my request, to file and release to any insurance company I may choose, any information necessary to process a claim for benefits. I understand that verification of my insurance benefits via phone/internet is not a guarantee of payment. I understand I am responsible for any unpaid balances not paid by my insurance. Any outstanding balances over 90 days past due will be turned over to the Collection Services of Athens for further collection procedures. A copy of this may be used in place of the original.

SIGNATURE: _____ DATE: ____/____/____

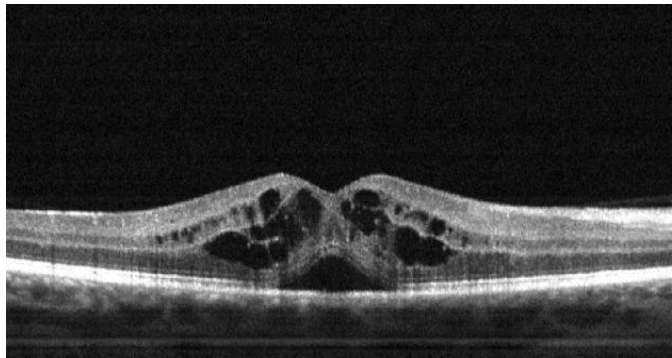
Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam™ SD- OCT retinal scan and Digital retinal imaging as part of your eye exam today. Our technician will perform these two tests before you go into the exam room and Dr. Robison will review these with you during your examination today. These two tests will become a part of your permanent patient record. The \$35 charge is not covered by your medical or vision insurance . This cost will be added into the price of your visit today.



Normal retinal photograph



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam often invisible to photos and ophthalmoscopy

- Yes, I would like the iWellness performed today
- No, I do not wish to have the iWellness performed today
- I would like to discuss the iWellness further with Dr. Robison

Signature _____ Date: ___/___/___

North Georgia Eye Care Cancellation / No-Show Policy

Here at North Georgia Eye Care we strive to provide the highest quality service possible to all of our patients. We are always happy to try to schedule appointments to accommodate your busy schedule. However, if you are unable to keep an appointment, we ask that you give us a 24 hour notice. Making your appointment as scheduled is very important, not just for us, but for you as well. Appointment times are in demand and a missed appointment is not only lost revenue for us, but an appointment time that someone else could have used.

If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 24 hours in advance. If you cancel your appointment without a 24 hour notice or if you fail to show up for your appointment time, a \$25 charge will be applied to your account. North Georgia Eye Care also reserves the right to cease rescheduling appointments due to habitual no-shows or cancellations.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy allows us to better schedule our patient's appointments at times that are convenient for them and is fair for everyone.

Thank you for your consideration and understanding on this matter and we look forward to your appointment time with us.

I have read the above and understand the cancellation / no-show policy of North Georgia Eye Care.

Patient/Guardian Signature

Date