



WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING:

Today's Date:

____/____/____

PATIENT INFORMATION				
LAST NAME MR MS MISS DR		FIRST NAME	MIDDLE	DATE OF BIRTH
HOME ADDRESS		CITY	STATE ZIP CODE	SOCIAL SECURITY NUMBER
MOBILE PHONE		ALTERNATIVE	EMAIL ADDRESS	
EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)		HOBBIES/SPECIAL INTERESTS	
HOW DID YOU HEAR ABOUT OUR OFFICE?				
IF THE PATIENT IS UNDER 18 YEARS OF AGE				
NAME OF PARENT/GUARDIAN		PHONE	RELATION TO PATIENT	
EMERGENCY CONTACT				
NAME OF EMERGENCY CONTACT		PHONE	RELATION TO PATIENT	
MEDICAL INFORMATION				
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	DATE OF LAST EYE EXAM	
MEDICAL INSURANCE COVERAGE				
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)		POLICY HOLDER BIRTHDATE	RELATION TO PATIENT
VISION INSURANCE COVERAGE				
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)		POLICY HOLDER BIRTHDATE	RELATION TO PATIENT

DIGITAL RETINAL IMAGING

Hazel Family Eyecare uses advanced technology to monitor early signs of ocular disease within your eye and the layers beneath your retina. Our Doctors recommend digital retinal imaging to patients of all ages and with all levels of eye health. **Please be advised that these options are not covered by insurance.**

_____ \$35.00 - Retinal Photography: This retinal image provides a broad view of the retina to help detect issues with retinal vasculature including retinal hemorrhages, pigment abnormalities as well as signs of macular degeneration. This photo is strongly recommended every year by our doctors.

_____ \$35.00 - Retinal Scanning: This is a scan of your entire retina providing a detailed analysis of the nine retinal layers and the choroid beneath. This aids in detecting fluid accumulation, central retinal detachments and macular degeneration among other diseases.

_____ \$49.00 for both services combined - this is the most comprehensive for overall eye health and wellness.

_____ No, contrary to recommendation, I am declining the retinal photo and wellness scan.

PRIVACY POLICY

Due to HIPAA laws doctor's offices must keep your information confidential. We have given you our policies regarding how we process your information separately. Please sign below stating you have read our statement. Your signature simply represents we attempted to share with you our HIPAA polices.

Patient/Guardian Signature: _____ DATE: _____

