

4Sight iCare Patient Forms

PATIENT'S NAME: _____

-if a minor,

GUARDIAN'S NAME (& RELATION): _____ (_____)

To acknowledge that the "Notice of Privacy Practices" is available to you, **initial here:** _____

Receiving care from another eye doctor? ___ No ___ Yes (Name): _____

PRIMARY CARE PHYSICIAN & PHARMACY

Doctor Name: _____ Practice Name: _____

Office Phone: _____ Office Fax: _____

Pharmacy (name & location): _____

REASON(S) FOR VISIT (CHECK ALL THAT APPLY):

___ Yearly Eye Exam ___ Eyeglasses ___ Contact Lenses ___ Medical Office Visit

EXAM OPTIONS:

___ **The iHealth Wellness Exam (+\$68):**

RECOMMENDED BY YOUR EYE DOCTOR every 1 to 3 years (based on results) & of course, ALL NEW PATIENTS. (This includes the iCam Retina Photo at no additional cost.)

OR

___ **The iCam Retina Photo Exam (+\$39):**

PERFORMED YEARLY to evaluate eye health. (This is the high-tech standard of care at an annual comprehensive wellness eye exam).

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.










SIGNATURE: _____ **DATE:** ___ / ___ / ___

Give your i-Care visit some 4-thought




















 CHECK ALL DISTANCES FOR WHICH YOU WEAR GLASSES/CONTACTS:

-  Far  Reading  Computer  None













How is your vision **with** your preferred vision correction for each distance?

- Far:  Acceptable  May need improvement  Blurry
 Near/Read:  Acceptable  May need improvement  Blurry
 Computer:  Acceptable  May need improvement  Blurry

 CHECK ALL THAT APPLY: score: (____)

How often do you experience:	All the time (4)	Most times (3)	Half the time (2)	Some-times (1)	Never (0)
Itchy eyes?					
Eye redness?					
Watery eyes (tearing)?					
Gritty/sandy sensation?					
Fluctuating vision?					

 CHECK ALL THAT YOU'RE EXPERIENCING RIGHT NOW:

	Eye pain		Eyestrain		Headache
	Double Vision		Burning		Discharge
	Poor Night Vision		Bothersome Glare		Light Sensitivity
	Total Vision Loss		Other: _____		None of these

Indications for dilation include but are not limited to: pertinent family/personal medical history, recent eye/head injury, abnormal tests results, or lack of iHealth Wellness Exam within 3 years. Not having a dilated eye exam when indicated and/or failing to attend a medical office visit may be detrimental to your health and vision.

Dilation is an important part of an eye exam. It opens the pupil to better evaluate eye health, but it has temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only drive once comfortable with your vision.

Pupil dilation is not recommended for patients who are pregnant, nursing, or allergic to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide).

Initial which best represents your wishes:

_____ **NO** dilation eye drops today. If medically indicated, I shall schedule it to be done.

_____ **Discuss** dilation with my doctor **if medically indicated.** This may add up to 35 minutes.