

## PLAN ahead:

- Plan on a 90-minute visit. We are comprehensive.
- Wear your contact lenses if you have them.
- Your eyes may be dilated, slightly blurring your vision for a few hours afterward.
  - Bring sunglasses for your comfort. You may want to bring a driver with you.
  - Persons with diabetes and children should expect to be dilated at least yearly.

## BRING the following with you:

- THIS form (or fax: 804-794-9216 / email: [office@theeyeplace.com](mailto:office@theeyeplace.com))
  - COMPLETE + SIGN the registration form.
- LIST of all medications, supplements, and eye drops you use
  - Many common medications have significant effects on the eyes.
  - Bring your eye drops.
- MEDICAL insurance cards
  - Cheaper: Copays may be *less* than vision insurance.
  - Limitations: Vision insurance *does not cover* injuries, pink eye, glaucoma, diabetes, etc.
  - Convenience: Kept on-file in case of emergency visits.
- Driver's License or ID card
  - This helps us protect your identity.
- All eyeglasses, sunglasses, and contact lenses
  - Wear & tear and misalignment are a major reason for vision difficulty.
  - BRING prescriptions from other offices, especially for contact lenses.

YOUR SUPPORT GOES BEYOND YOUR  
BEAUTIFUL NEW GLASSES.



**Locally owned and operated!**



LAST NAME		FIRST NAME		MI	NICKNAME
ADDRESS			CITY	ZIP	HOME PHONE <input type="checkbox"/> Preferred
PLACE OF EMPLOYMENT/SCHOOL	JOB / GRADE		DATE OF BIRTH	AGE	CELL PHONE <input type="checkbox"/> Preferred
SPOUSE / PARENT NAME	SOCIAL SECURITY NUMBER	EMAIL ADDRESS		WORK PHONE <input type="checkbox"/> Preferred	

MY PRIORITIES	
Y	N
I plan to order new glasses today.	
My driving sunglasses have my current prescription.	
I am considering LASIK (laser eye surgery).	
I plan to order contacts today. (+Free Shipping)	
I need an itemized receipt for my Flex Spending Account.	
I allowed time to be dilated today (+20 minutes)	
We ship ALL contacts to your work/home for free!	

MY HEALTH			
Y	N	Y	N
Detached Retina		Diabetes	
Cataracts		I am Pregnant/Nursing	
Glaucoma		I use tobacco	
Macular Degeneration		I Had Eye Surgery	
Eye Injury		I have sunglasses	
MY DOCTORS			
Name of Physician/Pediatrician: _____			
Name of Specialist(s): _____			

NEW PATIENTS ONLY	
Date of Last Eye Exam:	_____
Last Eye Doctor/Location:	_____
How did you find our office?	

CONTACT LENSES	
<input type="checkbox"/> I <u>wear</u> or want contact lenses	
<input type="checkbox"/> I was told I cannot wear contacts	
<input type="checkbox"/> I want color contacts	

ADVANCED EXAMINATION	
We will take pictures of the inside of your eye and test side vision to better detect glaucoma, diabetes, and macular degeneration. Your doctor will review new images each year. The fee for this is \$40.	

Additional Contact Lens Services			
Contact lenses are medical devices that require additional time and testing versus a routine eye exam. The fees for this service depend on the type of lens worn. Insurance may lower these fees.			
<u>Lens Types</u>	<u>Examples</u>	<u>Soft Contacts</u>	<u>Hard (RGP) Contacts</u>
		<u>Starting at</u>	<u>Starting at</u>
Distance Only		\$99	\$199
Distance and Near	Multifocal, Monovision, Bifocal	\$189	\$289
Myopia Care for Kids	Slows prescription changes	\$129/mo	\$129-\$199
3D-Printed Lenses	Keratoconus, Sclerals	Up to \$1200	Up to \$1200
<u>Included:</u> •ALL demonstration lenses •ALL related check-up visits for 60 days		<u>Excluded:</u> • <sup>†</sup> Contact lens lessons (\$25 per session) •Your yearly eye exam •Contact lenses and lens supplies •Visits and demos after your prescription is finalized	

My signature acknowledges that a copy of The Eye Place Optometry, P.C.'s Notice of Privacy Practices has been made available to me. I consent to examination and treatment and agree to pay for the care and goods I receive. This includes any copays, deductibles, and fees for not paying, like returned checks (\$50), certified mail, collections, arbitration, and attorney fees. If I do not pay my bill within 60 days of notice, the office can charge the most recent credit card used for payment to my account. I give permission for the office to share the information needed to process my insurance claims and I assign payments from my insurance company. I allow The Eye Place Optometry, P.C. to share medical information from my other doctors or medical facilities when important for my care. This office will decide which of my insurance plans should cover my services. I understand that payments for services are non-refundable. My medical records will be stored electronically indefinitely, and any paper documents with my personal information will be shredded to protect my privacy. I have read and understood these terms and agree to follow them.

PATIENT'S SIGNATURE _____	DATE _____
(parent or guardian if patient is a minor)	Please use reverse if you need more space →