



Welcome to All Eyes Optometrists

Thank you for returning to our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help. **Fees charged for professional services are non-refundable.**



Patient: _____ Date of Birth: _____

Has your address changed since your last visit with us? If so, please update below:

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Email: _____

If your insurance has changed, please fill out the reverse side of this form and give your new insurance card to our staff.

Please list any medications you are currently taking: _____

Please list any updates to your health history: _____

What brings you in to our office today: _____

Digital Imaging of the Eye : Anterior Segment and Posterior Segment Photographs

These procedures will take a digital image of the ocular tissues in the eye, including your cornea, retina, lens and conjunctiva. This allows the doctor to more closely monitor the health of your eye and assists with diagnosis and treatment of retinal detachments, cataracts and glaucoma. This procedure is highly recommended and our staff will be more than happy to check with your medical insurance to see if these procedures are covered. Otherwise, the cost for these procedures will be \$25.

Please initial the appropriate choice: _____ I consent to having digital images taken of my eye today.
_____ I do no consent to having digital images taken of my eye today.

Insurance

Name of who is responsible for this account: _____

Birthday: _____

Relationship to patient: _____

Insurance Company: _____

ID# / SSN: _____

Name of employer: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above stated company and assign directly to All Eyes Optometrsts all insurance benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize All Eyes Optometrists to release all information necessary to ensure payment of benefits. I authorize use of this signature on all insurance submissions.

Signature of patient (or a parent ifa minor): _____ Date: _____