PEACHTREE CITY
EYE CENTER

Peachtree City Eye Center

Retinal imaging consent form

In our continuing efforts to bring our patients the most advanced technology, our office is proud to announce the addition of the OPTOS Daytona Retinal Imaging Camera as an important part of your eye examination today. Our doctors are concerned about retinal conditions including macular degeneration and glaucoma, as well as systemic diseases such as diabetes, stroke and hypertension. These conditions can lead to partial vision loss or blindness, and often can develop without warning and can progress without symptoms.

The digital photograph provides:

a detailed view of the retina, which enables us to better monitor your eye health.
the ability to view your digital image with your doctor during your examination.
it provides a digital record of your retina that becomes part of your permanent file.

Digital Retinal Photography is painless and non-invasive. It is comparable to taking a baseline dental x-ray. In most cases, retinal imaging will NOT require dilation drops, which results in temporary blurred vision and light sensitivity. The doctors at Peachtree City Eye Center **highly recommend** all of their patients to have a retinal imaging procedure performed annually.

Because your insurance is designed to cover only a basic eye examination, it typically does not cover advanced screening procedures, such as retinal imaging. **The additional fee for this procedure is $39.00.**

_____**YES**, I would like to have retinal imaging performed today.

_____**NO**, I have read and understand the above information and DECLINE to have retinal imaging.

If you have selected **NO** to having the retinal imaging performed, our doctors recommend a dilated eye examination to assess the health of your retina. The dilation is part of your examination and is covered by your insurance. The dilation will cause blurred near vision and light sensitivity for approximately 4-6 hours after instillation.

_____**YES**, I would like to have my eyes dilated today.

_____**NO**, I would not like to have my eyes dilated today. I understand by declining dilation and retinal imaging, it limits the doctor's ability to thoroughly assess the health of my eyes.

Signature: _____ Date: _____

PEACHTREE CITY EYE CENTER

Patient Information

Name:_____ MI____ Last_____ Preferred_____

Circle one: Mr. Mrs. Ms. Miss Master Dr. Rev.

Mailing Address_____

City:_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Marital Status: Married Single Divorced Widow Circle preferred contact method: Home/Cell

Email:_____ Occupation/Employer_____

Age_____ Date of Birth_____ Sex:_____ Birth State_____

Account Responsible

Name:_____ Relationship to Patient_____

Date of Birth_____ SS#_____

Address(if different than patient)_____

Insurance

Vision Insurance & Policy #_____

Health Insurance & Policy #_____

Secondary Insurance & Policy #_____

Policy Holder Name & Date of Birth_____

Government Required Information

Please circle your answer

Primary Language

- English
- Spanish
- Japanese
- Other_____

Race

- Asian
- African American/Black
- Caucasian
- Decline to Answer

Ethnicity

- Hispanic or Latino
- Non-Hispanic or Latino
- Decline to Answer

Emergency Contact & Release of Information

I authorize this person to be contacted on my behalf in case of an emergency and for information to be released to them regarding my PHI (personal health information)

Name:_____Relationship:_____

Phone Number:_____

I also specifically authorize Peachtree City Eye Center to release my PHI (personal health information) with these additional people:

Name	Relationship	Phone Number

I, _____verify that all information given is correct to the best of my knowledge.

Patient Signature_____

Parent or Guardian Signature_____

Peachtree City Eye Center

CHIEF COMPLAINT: (What brings you in to the office today?)

_____

_____

Refractive History

Last Eye Visit: ___/___/_____ Dr: _____

Primary Care Physician: _____ Last Visit: _____

REVIEW OF SYSTEMS – Please circle any that apply:	
Constitution	Appetite Changes Fatigue Sudden Weight Change
Cardiovascular **MEDICATIONS:**	High Blood Pressure Chest Pain Heart Disease High Cholesterol Irregular Heart Beat Pacemaker Stent
Ears, Nose, Mouth, Throat **MEDICATIONS:**	Chronic Colds Chronic Sinusitis Sinus Pain
Respiratory **MEDICATIONS:**	Asthma Chronic Bronchitis Chronic Cough Wheezing Emphysema
Gastrointestinal **MEDICATIONS:**	Crohn's Disease Diarrhea Heartburn Irritable Bowel Syndrome Nausea Ulcers
Genitourinary **MEDICATIONS:**	Bladder Infections Changes In Color Of Urine STD
Musculoskeletal **MEDICATIONS:**	Arthritis Fibromyalgia Joint Pain Muscle Pain Osteoporosis Muscular Dystrophy
Integumentary **MEDICATIONS:**	Dermatitis Dryness Eczema Psoriasis Skin Cancer
Neurological **MEDICATIONS:**	Dizziness Epilepsy Migraines Stroke Depression
Endocrine **MEDICATIONS:**	Diabetes: Type 1 Type 2 HYPOthyroidism HYPERthyroidism

REVIEW OF SYSTEMS – Please circle any that apply:	
Hematologic/Lymphatic MEDICATIONS:	Anemia Hemophilia Leukemia
Allergic/Immunologic MEDICATIONS:	Seasonal Allergies Food Allergies: _____ Lupus Auto-Immune Disorder
PLEASE LIST ANY OTHER MEDICATIONS CURRENTLY TAKING:	
PLEASE LIST ANY KNOWN DRUG ALLERGIES:	

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY OR HAVE APPLIED:

Glaucoma Cataracts Age-Related Macular Degeneration Blindness

Strabiusms Amblyopia Diabetes

Eye Injury (Please Describe): _____ Retinal Disease: _____

Dry Eye: MILD MODERATE SEVERE

SOCIAL HISTORY	
Drugs	Type:
Alcohol	Beer Wine Liquor Amount: _____
Tobacco	Cigarettes _____ Packs/Day Current Smoker Former Smoker Never Smoker Cigars _____ / Week _____ _____ _____ Chewing Tobacco _____ Cans/Day

FAMILY HISTORY			
	Relationship:		Relationship:
Glaucoma		Blindness	
Cataracts		Strabismus	
ARMD		Amblyopia	
Eye Injury		Diabetes	
Retinal Disease		Cancer	
Other Disease		Heart Disease	

PEACHTREE CITY EYE CENTER

100 North Peachtree Parkway Suite 1 Peachtree City Ga 30269
www.ptceyecenter.com
Phone-770-487-8900 Fax- 770-487-4118

Patient Name:_____

Date of birth:_____

Consent for Medical Treatment, Release of Information and Privacy Notice

1. **Consent of Treatment:** I consent to necessary treatment including drugs, medicine, performance of in-office procedures, or other studies and tests that may be used by the doctor and staff.
2. **Authorization for Release of Information and Privacy Statement Notice:** Peachtree City Eye Center may release information from my medical records to any health care provider involved in my care and treatment. Peachtree City Eye Center may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, and third party payer or my employer who is providing payment due to injury on the job. I have received notice that Peachtree City Eye Center abides by HIPPA privacy policy.
3. **Financial Agreement:** I understand that I am responsible for all charges at the time of service and that there is no guarantee of payment from any insurance company or other payer. I understand that some routine services are not covered by my insurance and that I am financially responsible for all charges on the date of service. I agree to pay all charges for the services provided by Peachtree City Eye Center which are not paid by my health insurance or any other payer. This includes **copays, deductibles, glasses, refractions, contact lens evaluations and/or fitting, contact lenses, elective optos and any denied claims.** I agree to pay all reasonable legal expenses necessary from the collection of any debt. I understand that I am responsible for a $30 returned check fee I addition to any other associated bank charges.
4. **Assignment of Insurance Benefits:** I hereby assign and request that payment of all insurance benefits be made directly to Peachtree City Eye Center. Furthermore, I understand that I am financially responsible for any and all charges incurred while under the care of this office.

Patient Signature

_____ _____

Signature of Patient or Legal Guardian | Printed name of patient

_____ _____

Relationship if Patient unable to sign | Date