

Welcome to Klahanie Eye Care Center!

Date: _____

PATIENT INFORMATION:

Name (Last, First): _____ DOB: _____ SS# _____

Street Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____ Sex: M/F

Occupation: _____ Employer: _____

Please tell us how you heard about our office: _____

INSURANCE INFORMATION: Insurance for eyes can be confusing. Doctor visits relating to *vision problems (for ex. nearsightedness)* are covered by Vision Plans. Doctor visits relating to *medical problems (for ex. dry or itchy eyes)* are covered by your Medical insurance. Please provide both so that we may bill your visits appropriately today and in the future.

Vision Plan: _____ Subscriber's Name: _____ SS/ID# _____

Medical Plan: _____ SS/ID# _____ Subscriber's DOB: _____

Assignment and Release: I certify that I, and/or my dependents have insurance coverage with the above carriers and assign directly to Dr. Erickson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Your Signature (Patient or Guardian): _____ **Relationship to Patient:** _____

EYE HEALTH HISTORY: What is the main reason for today's visit? _____

Do you wear contact lenses? Y/N If yes, what brand do you wear? _____

Please circle all that currently apply to your eyes: Blurry Burning Dry Itchy Red
Floaters Light-Sensitive Headaches Discharge Pain Foreign Body Other: _____

FAMILY EYE HEALTH: Please circle all that have applied to yourself or any blood relatives:
Glaucoma Lazy Eye Retina Disease Macular Degeneration Other eye disease: _____

FAMILY MEDICAL HISTORY: Please check all that apply to you or any blood relatives:
Diabetes Cancer Respiratory Disorder Skin Condition Thyroid Condition Cardiovascular Disease
Migraines Gastro-Intestinal Disorder Kidney Disease Hypertension Immune System Disorder
Allergies Other major health problems: _____

Which of the above apply to you? _____

MEDICATIONS: _____

ALLERGIES: _____

Do you smoke? Y/N How much? _____ Do you use alcohol? Y/N How much? _____
Are you pregnant? Y/N

Annual Contact Lens Service Fees

A very common source of confusion in any eye clinic is the issue of fees required to be prescribed contact lenses. This page has been created to clear up any confusion before any contact lens related services are performed. Please read below. If you have any questions, please ask a staff member or your doctor.

Contact lenses are medical devices that require proper care and monitoring to ensure good vision and ocular health. **A Contact Lens Service or “Fitting” is the time and knowledge required to prescribe the most appropriate contact lenses for you and your eyes.** This service is *in addition* to your annual eye health exam and is typically not covered by vision plan exam benefits. The contact lens service fee varies by the complexity of your eyes, the type of contacts you require, and the amount of time necessary to achieve a proper fit. This fee is due at the time of your annual exam and is non-refundable.

The service fee covers all “fit-related” follow-up visits for 3 months. Office visits related to medical conditions that may develop will be billed to you *medical insurer*. Contact lens service fees for the most commonly used lenses are listed below.

Daily Disposable Contacts	\$89
14 Day or 30 Day Disposable Contacts (spherical or toric)	\$89
Rigid Gas Permeable Lenses (spherical)	\$139
Soft Bifocal Contacts	\$139
RGP Bifocal Contacts	\$189

If you are a first time wearer of contact lenses a \$30 fee will be charged for a contact lens lesson.

When purchasing soft contact lenses, your best value is to purchase a one year supply. The advantages of purchasing a one year supply of soft lenses are:

1. Most manufactures offer a rebate.
2. You’ll be given a card good for \$100 off prescription glasses or \$50 off non-prescription sunglasses.
3. You’ll receive a \$30 discount if you order within 30 days of your contact lens evaluation.

I have read and understand the Contact Lens Service policies of Klahanie Eye Care Center.

Initial _____

I would like my Contact Lenses *evaluated* and my *prescription updated*.

Please Circle: Yes No